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LACK OF HEALTH INSURANCE COVERAGE IN THE UNITED STATES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

JULY 25, 1988

(Part 2 of 2)

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LACK OF HEALTH INSURANCE COVERAGE IN THE UNITED STATES

MONDAY, JULY 25, 1988

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:07 p.m. in Room SD-215, Dirksen Senate Office Building, Hon. George J. Mitchell (chairman of the subcommittee) presiding.

Present: Senators Bentsen, Baucus, Mitchell, Riegle, Rockefeller, Chafee, Heinz, and Durenberger.

[The prepared statements of Senators Mitchell, Riegle, Rockefeller, Chafee, and Durenberger appear in the appendix.]

[The press release announcing the hearing follows:]

[Press Release No. H-31, July 14, 1988]

FINANCE SUBCOMMITTEE ON HEALTH TO HOLD HEARING ON THE UNINSURED

WASHINGTON, DC.-Senator George Mitchell (D., Maine), Chairman of the Senate Finance Subcommittee on Health, announced Thursday that the subcommittee will hold a hearing on the problems resulting from the lack of health insurance coverage in the United States. An estimated 37 million Americans lack health insurance coverage.

The hearing is scheduled for *Monday, July 25, 1988 at 2 p.m.* in Room SD-215 of the Dirksen Senate Office Building.

Senator Mitchell said, "Access to affordable health care is an important issue. More Americans are working and our Nation's income is increasing. Yet, more of our children have no health insurance. More pregnant women have deficient prenatal care. More people, the majority of whom are workers and their families, have no health insurance and suffer from unattended medical conditions. This hearing will begin consideration by the Subcommittee on Health of this important problem."

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS

The CHAIRMAN. This hearing will get under way. Chairman Mitchell is managing a bill on the floor of the U.S. Senate, and I am sure he will be along any moment. I have been told he is on the way; but knowing of our time constraints, I would like to bring this session to order to get the hearing started and to make an opening statement.

I would say first how pleased I am that Chairman Mitchell is holding this meeting on health insurance. We have more than 37 million Americans without health insurance. We have seven million more than we did just back in 1980; and what is of particular

concern to me is that we have some 12 million children who don't have access to either private or public health insurance.

Now, I think that failure to give children financial access to basic health care imposes substantial medical, emotional, and economic costs, not only on those children but on society as a whole. It is the nation that suffers when young children are not given a good start in life, when they are not brought into this world with sound minds and bodies, when they are not carried through those first years with adequate health care.

There are just no simple approaches to this complex problem of improving access to health insurance, but we have made a lot of progress in this area here on the Finance Committee; for example we have expanded Medicaid eligibility for poor pregnant women and infants and have proposed using Medicaid to help welfare recipients returning to work obtain health insurance.

But a lot more remains to be done. For example, we know that 20 percent of uninsured children live in families that have health insurance; and, for one reason or another, the employer has not provided dependents' coverage.

There are many reasons why a child might not be covered under the employer's plan, but that is one of the things that we have to explore here today as we work to find ways to improve greater access to health insurance in our country.

I would like to defer now to any of my colleagues who might have a statement.

Senator ROCKEFELLER. Thank you, Mr. Chairman. I do.

The CHAIRMAN. Senator Rockefeller?

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER, IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Under Your leadership, Chairman Bentsen, this committee has made major progress on health issues that affect children. I would like to reemphasize what you said a moment ago. Of the 37 million Americans that do not have insurance, one-third of those are children.

Quite frankly, in my own State of West Virginia, the situation is scary. Entire families are without any form of health insurance coverage. There are 30,000 more uninsured persons in West Virginia today than just back in 1980. Sixteen percent of all West Virginians are without any form of health insurance.

There are 54,000 children in West Virginia who are uninsured, even though at least one of their parents is working; only 37 percent of West Virginians with incomes below the poverty line are receiving Medicaid benefits.

The problem, I assume, is as severe in other places also. It is not one that will be easily solved. It is one which the public and the private sectors will have to work together, to solve. It is a staggering and tragic problem that affects workers and nonworkers; children and adults; the sick and the healthy; and the poor and the not so poor.

We have got our work cut out for us. We have got to do it in a responsible way. We have to be able to develop legislation that

works, and I am glad that we are getting at that task. As I say, it is a scary situation, Mr. Chairman, and I thank you.

The CHAIRMAN. Thank you very much, Senator Rockefeller. Senator Heinz?

Senator HEINZ. Mr. Chairman, first I would ask unanimous consent that my statement be included in the record.

The CHAIRMAN. Without objection, that will be done.

OPENING STATEMENT OF HON. JOHN HEINZ, A U.S. SENATOR FROM PENNSYLVANIA

Senator HEINZ. Mr. Chairman, this is a subject that the Subcommittee on Health has had a great interest in. I have been privileged to serve as a member of that subcommittee for many years. Under Senator Mitchell's chairmanship—and you are right; he is on the floor managing the Endangered Species Act—he authorized this subcommittee to hold a hearing in Wilkes Barre, Pennsylvania about a month ago, which I was privileged to chair, on this very subject, to gather some information in the field.

I won't take the time or effort to recap the substance of that hearing, but I would like to draw to our colleagues' attention to useful elements that were developed in anticipation of that hearing.

One is a report for the Special Committee on Aging, of which I am ranking member, and the Committee on Education and Labor in the House, which is a very good compact source of data on this issue; and I commend it not just to the members of this subcommittee or the Finance Committee, but to all our colleagues because it goes into some detail on the kinds of points that Senator Rockefeller was making. And those who are uninsured are a surprisingly complex and difficult group to really address with any single solution.

Second, I would also ask unanimous consent to make available, through the hearing record, a series of working papers on health insurance that have resulted from a task force of business, labor, and insurance companies that our committee put together over a year ago that I think members will find interesting and very useful as we deliberate a policy on this issue.

I would close by saying that there was one witness at our hearing who gives you an idea of how difficult it may be for us to find any single solution as the right answer; and this was the case of a family named McNaney of Bucks County, a farming family.

Mrs. McNaney testified at our hearing that her father-in-law couldn't get group health insurance for their small family farm, which employed her husband and another worker. The individual policy the family could afford was woefully inadequate. They chose a cheaper policy because they couldn't afford the more expensive one.

Their 12-year-old son, as luck would have it—bad luck—needed emergency surgery, left them with a debt to the hospital of some $15,000; and they decided that they could not continue to go under underinsured. So, they bought a very comprehensive policy, costing them in the neighborhood of $3,000 plus a year.

They still have out-of-pocket costs such that, between the policy that they purchased and their out-of-pocket costs, they have $4,500 a year plus $2,500 a year repaying the hospital the money that they owe them, on a gross income—before deductions for Social Security, taxes, and everything else—of $28,000.

So, you do not have to be poor to be badly off. You do not have to be poor or unemployed or even underemployed to find health insurance either unaffordable or, for all intents and purposes, inadequate or unavailable.

The CHAIRMAN. Thank you very much, Senator Heinz. Looking over the list of witnesses, I can't help but be very much impressed with the quality of the witnesses we have. You are going to hear some divergent points of view, but that is good, as we evaluate these proposals and try to determine what is best for our country as we try to increase health care and health insurance availability.

Now, the first panel will consist of Robert J. Blendon, Professor and Chairman, Department of Health Policy and Management, Harvard School of Public Health; and Karen Davis, Professor and Chairman, Department of Health Policy and Management, Johns Hopkins School of Hygiene and Public Health.

We are very pleased to have you both. Dr. Blendon, if you have a prepared statement, would you proceed?

STATEMENT OF ROBERT J. BLENDON, SC.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, HARVARD SCHOOL OF PUBLIC HEALTH, BOSTON, MA

Dr. BLENDON. I am Bob Blendon. I appreciate the opportunity of being able to testify. Those who follow the health care field have discovered that we are probably living in the period of the most rapid change in the post-World War II era.

Likewise we are in a period of probably the most sweeping changes in American health care. In this world, people continually ask the question: Do people without health insurance manage to get health care in this country?

What I would like to summarize briefly for you is the data from a large-scale UCLA Robert Wood Johnson Foundation Survey.

Point one, most Americans have health insurance and report almost no problems in obtaining medical care. Point two, the world totally changes for those people who do not have health insurance; and I am going to give you quickly four illustrations from the survey.

First, take 100 people who say they are sick and have health insurance and 100 who say they are ill and don't. Those without health insurance end up in a doctor's office 40 percent less often. Take 100 children without health insurance, 100 children with health insurance. The children without health insurance see a doctor 34 percent less frequently.

Take the recommendations of a panel of physicians. One hundred doctors came up with a list of symptoms, and they said: If you have these symptoms, see a doctor: pain in chest when you are exercising; unexplained bleeding; fainting frequently. Take 100 people with those symptoms with insurance and 100 people without insurance.

What they found was that insurance, the majority of people with pain in chest, unexplained bleeding go to a doctor. If you do not have health insurance, the majority of people do not go to a doctor.

Last issue, as a newspaper friend of mine likes to say: No problem; why don't they march off to see a doctor, go to a hospital emergency room? The survey found one million people who reported they marched off to see a doctor, were turned away either at a hospital or by a physician, and they were all either uninsured or poor.

Now, I want to quickly summarize for you why the underpinnings for the safety net, which is mostly hospitals and public hospitals, is falling apart in today's world. And the people who testify before you will imply that it is all health insurance.

Actually, there are four other things going on, and I want to hit them very quickly.

The first is take America's 100 largest cities; a third of them don't have public hospitals any more. Senator Heinz, Philadelphia General Hospital is gone. That is true in major cities across this country. We closed one-third of our public hospitals; they are not there.

Two, the insurance coverage has gone down by 25 percent. Three, Medicaid coverage for low income Americans is less today than it was in mid-1975. Four, my world—and I came from the world of private philanthropy—in 1970, if you had $100 in the health field, $4.50 came from generous Americans who were willing to provide some sort of subsidy. In today's world, it is $2.50, which means in the nonprofit world, the glue—that critical giving money that used to be there—isn't there any more.

Lastly, there has been a fundamental change in the attitudes of business and labor about subsidizing people without insurance in hospitals. We used to have an unwritten covenant, which I like to call the equivalent of the scholarship to a parochial school; that is, when you were in a hospital, we charged middle class people more money to cross subsidize them in the bed or the outpatient department.

In recent years, that covenant, whether it be with Blue Cross or commercial insurance, has been broken. People want to pay "for their own." These five things have come together to make it extremely difficult for what, in the public's mind, is the safety net for the uninsured, which is public hospitals, nonprofit hospitals, and free clinics, to provide people without insurance with health care.

That is what the data reflect and that is the problem that I think we are talking about today. Thank you.

[The prepared statement of Dr. Blendon appears in the appendix.]

OPENING STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM MAINE

Senator MITCHELL. Thank you very much, Dr. Blendon. Dr. Davis, welcome. As always, we look forward to hearing your testimony.

STATEMENT OF KAREN DAVIS, PH.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, JOHNS HOPKINS SCHOOL OF HYGIENE AND PUBLIC HEALTH, BALTIMORE, MD

Dr. DAVIS. Thank you, Senator Mitchell. I will submit my statement for the record and just highlight some points for the committee. I am pleased to have this opportunity to testify on the absence of health insurance coverage and its implications.

As the cost of health care has risen sharply over the last decade, as Senator Heinz noted, even families with moderate incomes can face devastating medical care bills unless they are protected by health insurance.

Fortunately, about 85 percent of all workers and their families receive such health insurance from their employers. For a significant minority, however, gaps in employer-provided health insurance pose significant barriers to needed medical care and undermine the health and economic security of families struggling to earn a livelihood.

As Senator Bentsen noted, particularly alarming is the fact that access to health care in this nation is becoming worse, not better; and the ranks of the uninsured are swelling. Senator Bentsen mentioned that there are 37 million Americans without any health insurance coverage; about two-thirds of these are individuals who are working nearly full time.

About one-third of the uninsured are children; Medicaid picks up only about 40 percent of the poor and excludes many poor individuals because of income eligibility levels that are set well below the Federal poverty levels and because categorical restrictions limit coverage largely to one-parent families.

One-third of the uninsured have incomes below the poverty level; only about 20 percent have incomes in excess of three times the poverty level. About one-half of those who are employed and uninsured work in firms with fewer than 25 employees.

Employer-provided coverage is particularly low in industries such as agriculture, construction, retail trade, and services. Our reliance upon an employer-provided system of health insurance on a voluntary basis results in health insurance coverage being largely a matter of luck.

The growth in the number of uninsured is linked in part to the increasing tendency, as has been noted in several statements today, for employers to cover only the employee and not the dependents; so that we have many children and spouses who are not covered under a family health insurance plan.

There are a number of options that might be pursued to extend health insurance coverage. One might expand public programs, such as Medicare and Medicaid. One might use public funds to subsidize the purchase of individual health insurance. One might tax hospitals or health insurance plans to create a pool of funds for the uninsured. Or one might require employers to provide health insurance for their workers and dependents.

The first of these alternatives of extending Medicare and Medicaid to cover all of the uninsured would require substantial new taxes. The second approach of subsidizing the purchase of individ-

ual health insurance policies is inherently inefficient, as we have noted from the high premiums that were cited for individual health insurance coverage.

The third approach of setting up pools that tax hospitals or health insurance plans puts a double burden on those employers that provide coverage to their workers. In effect, they pay not only for their own workers, but for the uninsured as well through higher premiums that they pay.

The fourth alternative, simply requiring employers to provide basic health insurance coverage for their workers, has much to commend it. It would minimize new taxes required; it would build on the current system of employer-provided health insurance coverage. It would spread the cost of expanded coverage more equitably among firms; and it would permit limited public funds to be targeted onto low income individuals not covered by employer plans.

Therefore, I would like to suggest to the committee for consideration a partnership between the public and private sectors to begin to close the gap in coverage. This proposal would have two major components: requiring a basic health insurance plan to be provided by employers to full-time workers and their dependents, and providing residual coverage under Medicaid available to everyone falling outside employer plans on a sliding scale premium contribution basis.

The provisions of an employer basic health insurance plan should be kept modest to keep premiums affordable; however, I think in light of what we have heard about the problems of children, that features such as comprehensive prenatal delivery and infant care without cost sharing is an important feature of such plans.

An employer approach has been criticized because it might pose an economic burden on low-wage firms. However, my estimates are that there would be only a modest employment loss that would be more than offset by expanded jobs in the health sector. There are various tactics that could be pursued to make it economical for small firms.

The Medicaid program could be expanded to include all of those with incomes below the poverty level. We have brought in selected groups of pregnant women and children over the last few years, but there are still many poor people not covered by Medicaid. We could continue incremental expansions in this program to cover all of those who are poor and permit those with incomes slightly above the poverty level to purchase Medicaid coverage on a sliding scale basis.

This would cover nearly all of the uninsured: about 22 to 24 million would be covered under an employer plan and the remaining 13 to 15 million would be covered under an expanded Medicaid program. Thank you.

[The prepared statement of Dr. Davis appears in the appendix.]

Senator MITCHELL. Thank you very much, Dr. Davis.

Senator MITCHELL. In the interest of time, I will have my opening statement placed in the record. Senator Bentsen, questions?

The CHAIRMAN. Dr. Blendon, when you were commenting on the public hospitals being closed and you were talking about the prob-

lem of these children having accessibility to health care, what happens to them when they don't get it?

Dr. BLENDON. The answer is that a significant number of children just do not see a doctor, period. And one of the things that we struggle with is: How do we know how things work out? For the group, one of the tables that I included was the most recent data comparing the experience of our young infants with that of our neighbor, Canada.

I want to be on record here that I am not advocating bringing anything down from Canada, but I think we could look at this very carefully and discover that not only in the last decade has the U.S. infant death rate not kept up with Canada; but at the moment our White infant death rate for children has now fallen below that of our neighbors.

So, the answer is that a significant number of children do not get care when, in fact, they don't have insurance; and they are often at the most vulnerable points in their lives.

The CHAIRMAN. What happens to the health care provider who goes ahead and provides that care for the uninsured? What is the effect on the health care provider?

Dr. BLENDON. What we see—and Dr. McCarthy from the American Hospital Association will testify to this later—is that we have a group of hospitals that are struggling to support and finance the uncompensated care, which is nearly $10 billion this year, that they are providing.

And that tends to be concentrated in about a quarter of the institutions; and those institutions, have an enormous difficulty in trying to finance that care. The reason why I wanted to mention the Medicaid coverage and the philanthropic coverage and the unwillingness of business and labor to cross-subsidize is that most of the public—myself included—assume the hospitals will handle this like they always have.

They would sock it to some other payor; Medicaid will pay them; charity will have another fund-raising dinner. And what happens is that we are locking out those hospitals from getting at that revenue; and somewhere down at the end of the line, the children are going to hear that there is no room at the inn here because we can't get that other revenue.

The CHAIRMAN. Dr. Davis, when you were talking about a basic premium—basic coverage—and supplemental covered in other ways and means, and you said most of these people who are uninsured are in the smaller firms—as I understand it———

Dr. DAVIS. About half.

The CHAIRMAN. About half?

Dr. DAVIS. Of the firms have fewer than 25.

The CHAIRMAN. What kind of a cost might those firms incur? Can you give me a feel for what their operating costs might be, percentage-wise?

Dr. DAVIS. I can relate it to their labor costs. It would come to about 50 cents an hour; it works out to be about $1,000 per worker. That is an average of those who have an individual policy and a family policy.

So, in terms of the labor costs for a low wage firm—

The CHAIRMAN. If you had someone at $4 an hour, are you talking about $4.50?

Dr. DAVIS. It would be about a 12 percent increase in that labor cost.

The CHAIRMAN. For what you would think of as basic coverage?

Dr. DAVIS. That is correct. Basic coverage would include hospitals, physician services, comprehensive prenatal delivery and infant care, lab and X-ray type care. And that would include some cost-sharing, a deductible, and some co-insurance in the plan; about a $500 per family deductible, 20 percent co-insurance, and a $3,000 maximum out-of-pocket ceiling.

So, it is not total coverage even for such a family.

The CHAIRMAN. But once you had done that, in addition to what is covered already, you would be up to about what figure? About 24 million of those 37 million?

Dr. DAVIS. That is correct. It would cover the 24 out of the 37 million; two-thirds are in families where somebody works about 17.5 hours a week.

The CHAIRMAN. Thank you. Mr. Chairman, I unfortunately have some other commitments, but I did want to come by and tell you how much I appreciate the fact you are holding these hearings on such an important subject.

Senator MITCHELL. Mr. Chairman, I think I can speak for all the members of the committee in saying that we hold you in the highest regard, respect, and affection; and we are all pleased with the events of the past week and wish you the very best.

The CHAIRMAN. Thank you very much.

Senator MITCHELL. Is that safe enough, John? (Laughter)

Senator HEINZ. We wish you a speedy journey.

Senator MITCHELL. Senator Heinz?

Senator HEINZ. Dr. Davis, one of the problems noted at the hearings that the Health Subcommittee held—and I referred to them earlier, Senator Mitchell—that we had up in Wilkes Barre, Pennsylvania is that right now for the most part if you are an individual or if you are a small employer, it is very costly to purchase health insurance.

This is largely because most insurers from whom you would purchase it do not community rate; they experience rate. You gave an estimate of 50 cents per hour or $1,000 person. I gave the example of somebody who is paying $4,500 to cover their family.

Clearly, that is a very big difference. What should we do about the fact that insurers do not community rate? They experience rate; they deny coverage, or make it very costly to have people with preexisting conditions covered, and those kinds of problems.

Dr. DAVIS. I think that is a difficult problem. This particular plan—and it has cost us, let's assume, a 15 percent administrative cost—large groups run about a 10 percent administrative cost on top of benefit payments. Individual insurance plans many times are 50 percent or higher. So, many individuals have——

Senator HEINZ. Also, small group insurance is no bargain either.

Dr. DAVIS. Small groups have a hard time purchasing a plan, plus as you mentioned they often exclude preexisting conditions. This particular plan would require coverage of everyone in the group.

There are a number of approaches as to how to get this.

Senator HEINZ. But at what cost to the employer?

Dr. DAVIS. That is right. There are a number of approaches to trying to get that premium down so that the administrative costs, the profits, the add-on to the policies——

Senator HEINZ. It is not just the administrative costs. It is that small groups, as we got testimony from a variety of people, are a larger risk; or at least they are viewed as a larger risk.

Dr. DAVIS. That is right.

Senator HEINZ. To the people who write the insurance.

Dr. DAVIS. So, there is a higher margin to protect the company.

Senator HEINZ. So, it is not just administrative costs; it is just a much higher cost. Now, if we go out and do what you suggest, which is to mandate insurance, it might be that if you community rate it, your estimate of 50 cents per person per hour would be accurate.

I don't know whether that is the right number or not, but I can guarantee you that some employers in my State of Pennsylvania would be paying 75 cents or $1 an hour for the exact benefit package you described, simply because that is what they would be charged.

Dr. DAVIS. I think that is a problem you have to worry about. I have suggested some options in my testimony that include looking at the possibility of letting small employers purchase Medicaid coverage, which only has a 3 to 5 percent administrative cost and doesn't have that allowance for risk.

A second option would be to try to set up some type of reinsurance for small firms. Another one is to create incentives from multi employer groups, particularly firms in the same industry—for example, restaurants in a given town—to try to form a larger group by merging a number of smaller firms.

Another approach that is in a bill that Senator Kennedy and Congressman Waxman have introduced would be to select insurers to provide the small group coverage in a given geographic area through a competitive bid process so they are assured of getting all the small group business in a given area.

So, there are a number of options for dealing with that. I think you will learn more about the views of different organizations this afternoon.

Senator HEINZ. You would not favor a mandate of community rating then?

Dr. DAVIS. I think there are different approaches to dealing with that, and the problem is to get a premium or a cost that reflects the benefit payments of the group as a whole without adding a lot for taking on the risk.

Senator HEINZ. Dr. Blendon, do you have anything you would like to add in answering that question?

Dr. BLENDON. The problem you have by community rating alone is that a number of companies and unions—for non reasons of just people being sick—are investing a lot of their effort in trying to control their own health care costs. And it has taken almost a decade to get the idea of controlling the health care costs as an interesting issue into the work place.

If we need to adjust for some of the adverse experience, we don't want to take away from the business community or the unions to watch their utilization experiences. So, we have to adjust for that, but we have spent a long time getting the industrial community concerned about utilization.

Senator HEINZ. Thank you very much.

Senator MITCHELL. Thank you, Senator Heinz. Dr. Davis, I was interested in all of your comments, but particularly your remark that you thought mandating benefits by employers would produce a net increase in employment. You are obviously aware that one of the principal arguments against requiring employers to provide basic health insurance is that it would cause the loss of jobs as employers sought to compensate for the increased costs.

You have some specifics in your written statement regarding the so-called "10 percent effect." I wonder if you can provide us with a little more detail on that. How confident are you of the estimates that you have provided? And what you have suggested is that the increased jobs in the health care field will be greater than the decrease in jobs among nonhealth care employees whose employers are required to provide that health insurance.

Dr. DAVIS. Right. I am comfortable in estimating that it is roughly no net effect on jobs. There might be a net increase in jobs, but I wouldn't go that far.

Basically, to look at it, there are 4 million individuals with wages, say, below $4 an hour who are uninsured. Extending health insurance coverage to that group with a 15 percent increase in their labor cost to their employer could result in a 1.5 percent loss of those four million jobs. That comes to about 60,000 jobs.

So, that would be what economists using some of the minimum wage literature would estimate would be the employment loss of mandating this health insurance coverage.

On the other side, the Congressional Budget Office estimates that having employers provide this type of care would increase spending in the health sector by $10 billion. That is about a two percent increase in our $500 billion health industry.

If you had about a two percent increase in jobs in the health sector, you would be talking about 100,000 to 120,000 new jobs. So, I think on the conservative side, you would have a plus job effect, not a negative job effect.

Senator MITCHELL. And what is it that you propose with respect to Medicaid coverage?

Dr. DAVIS. The mandated employer coverage of a basic health insurance plan would cover 22 to 44 million out of the 37 million. That leaves you with 13 to 15 million individuals who still would not have any health insurance coverage.

Senator MITCHELL. Because they would not be employed?

Dr. DAVIS. That is right—out of the labor force. There are about 7 million of those with incomes below the Federal poverty level; and whether it is done all at once or incrementally as the budget can afford it, the basic proposal would be to extend Medicaid coverage to those 7 million with incomes below the poverty level.

Another 3 million have incomes between the poverty level and twice the poverty level—to let them purchase Medicaid on a sliding scale premium contribution basis; and for the remaining five mil-

lion, above twice the poverty level, let them pay the full cost of that coverage.

Senator MITCHELL. Now, those States which have established programs to deal with the uninsured have done so independent of Medicaid. Are you concerned about the effect of the proposals you make with respect to those persons above the poverty line? Are you concerned that that would transform Medicaid in a way that would cause a loss of political support for the program, that is, going above the poverty line?

Dr. DAVIS. There are a variety of issues there- analytical and political. In terms of the plan, I think you have to ask yourself: Do you need to income relate the features for those above the poverty level? If you do, say between an income of $11,000 and $15,000, you are going to have a greater contribution or greater premium by those with higher incomes.

Then, I think Medicaid is a good administrative device because they have systems set up for evaluating individual income, where at private insurance companies don't typically turn over private income data. So, that is one issue.

If you are going to subsidize on a sliding scale basis for the near poor, I think Medicaid makes sense.

The other issue, if you are providing coverage through a State pool or through private health insurance, has to do with how much of an add-on do you have to pay for having the company take the risk. And if it is going to be substantial, I think you are better off with Medicaid, with a five percent administrative cost.

Senator MITCHELL. Dr. Blendon, I have just one question for you. Your fourth conclusion in your statement is: "America's leadership groups are still struggling to find a consensus on how to resolve this problem." I have no disagreement with that statement.

What do you think about Dr. Davis' proposal? Do you favor mandating employers to provide basic health insurance?

Dr. BLENDON. I favor encouraging employers and, if necessary, mandating it. Yes. I have one issue I would like to raise in regard to Dr. Davis' proposal.

The Congress has just dealt with the welfare reform issue. One of the most critical issues in welfare reform is that when people try to go off welfare, we have a 1-year extension for Medicaid; and then they are back with the same problem. We must create a system where people have an incentive to leave the welfare system and make sure their children are covered by insurance.

That is absolutely critical for moving more people off that welfare system into employment, and that issue is not well touched by the welfare reform argument; and that is critical here. If you have insurance in the work place, people have an incentive to get off that system onto jobs where their children are covered by insurance. That is absolutely critical.

Senator MITCHELL. Thank you, Dr. Blendon. My time is up. Senator Baucus?

OPENING STATEMENT OF HON, MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman. Dr. Blendon and Dr. Davis, I would like you to address potential solutions to the disproportionate impact that a lot of these proposals will have on small business. I come from a small business State; we don't have a lot of big business in my State.

It is apparent to me that most of these proposals and most of the bills before the Congress address a very necessary problem, that is the uninsured; but the burden tends to fall disproportionately on small business. I am wondering how we handle that.

In many cases, big business has lots of advantages; and it is easier for them to adjust in all kinds of ways; small business has a harder time making ends meet. What are some of the better ideas that you have heard that address that problem?

Dr. DAVIS. I understand the problem of small businesses; but I think currently we have a situation where large businesses are incurring this cost and sometimes even in the same industry. I know we are not talking about Montana, but say in the airline industry, you would have a firm providing health insurance to their workers, another firm not providing such coverage; and there the burden is disproportionately on the firm that provides the coverage, trying to compete against firms that aren't.

So, I don't think it is universally the case that it is the small businesses that are hit.

On the other hand, I do know that for many of them——

Senator BAUCUS. I must say that, on the chart I have here by the Employee Benefit Research Institute, most of the uninsured are firms that are under 25.

Dr. DAVIS. That is because they are not providing the coverage now. So, they are the ones who would be incrementally affected by a policy that requires them to provide that coverage. On the other hand, for example there hasn't been an increase in the minimum wage since 1981; so that is a savings to employers because we haven't done that.

So, we are really asking them to take 50 cents in additional costs to provide some basic health insurance coverage to their workers. There are ways of getting it down. You could juggle the percent share between employers and employees. Right now, this particular bill requires employers to pick up 80 percent of the premiums; you could make it somewhat less.

There have been some who have looked at some ways of having tax credits to offset some of the impact on the small firm, or to subsidize it through some offsetting tax credit. That is another approach that could be looked at.

But in general, we think about firms' responsibility to provide a decent wage to their workers.

Senator BAUCUS. I understand that point, but if you were a small business person, I think you would tend to see this in a different light. Small business people have a harder time.

For example, if you are a big business, you get a deduction or credit if you provide luncheon services on your premises. Most small businesses aren't big enough to have a cafeteria on their

premises or to take advantage of that break. The Code is just riddled with all kinds of ways that big business gets a better break—if you add them all up—than small business.

I think frankly there is no doubt that we have to find ways to address the problem of the 37 million uninsured people in this country. It is a big problem; it has to be addressed. But the tendency is for us to pass across-the-board approaches which have the effect of disproportionately adversely affecting smaller businesses.

And I don't know if we want to do that. One reason I don't know if we want to do that is because 80 percent of the new ideas and growth in this country are really from small business; it is not big business. It is small business that comes up with most of the new, innovative ideas, the patents, new technological developments, and so forth. It is not big business.

I just think that the time has finally come where we have to spend more effort and more time effectively finding the kinds of solutions that you are touching on, namely a different percentage requirement for a smaller business or some kind of a tax break or something because my sense is that we are getting close to reaching the breaking point for a lot of the small businessmen.

Believe me, I am all for the goal we are trying to accomplish here, but I think we have to be a little more creative in how we find the solution.

So, I encourage both of you and others interested in this to look and try to find ways in which to address this.

Dr. BLENDON. Senator, the two States that have enacted mandated bills—Hawaii and Massachusetts—have put in a five percent of wages stopgap. Now, we only know the Hawaii experience and not very well, where they have tried to look at the impact, not because you are small, but because of what it does on the economics of the firm.

The one thing I would suggest, just having lived through the Massachusetts experience, for people to take a look at is who the small businesses are. In Massachusetts, many of the concerns of the small businesses are highly well off professionals—law firms, accountants, high tech technologies. At the other end are struggling minority businessmen.

Senator BAUCUS. That is right.

Dr. BLENDON. The approach taken by the two States which look at the impact on the economics of the firm, as distinct from how many lawyers are employed in the practice, is a very important issue.

Senator MITCHELL. Don't be too tough on lawyers now.

Dr. BLENDON. I am sorry. (Laughter)

Senator MITCHELL. A better example would have been——

Dr. BLENDON. Doctors.

Senator MITCHELL. Doctors. Right. (Laughter)

Senator BAUCUS. I tend to disagree with that, Mr. Chairman. I am a lawyer, too, and there are too many of us in this society. Could you please finish your answer to the question? It was very interesting.

Dr. BLENDON. Just looking at whether or not it has a disproportionate impact on the wages of a small firm is the best way to pro-

vide assistance, not just looking at whether or not the firm is small.

Senator BAUCUS. And you say that Massachusetts——

Dr. BLENDON. Massachusetts have a five percent cut-in for firms in distress, if it is more than five percent of their wage costs. And they have enacted a situation which I am nervous about, where they have exempted businesses below five, with the idea that the State will help with the subsidy.

That creates an incredible incentive for those of us who are seven to become five; and also, it doesn't deal with the fact that many small firms are doing very well, and what you want to do is help those where the actual bill affects their income picture.

Senator BAUCUS. They also have a different category for professional service organizations.

Dr. BLENDON. Right, high tech and others that fall into that category.

Senator BAUCUS. Yes. Thank you.

Senator MITCHELL. Thank you, Senator Baucus. Senator Durenberger?

OPENING STATEMENT OF HON. DAVID DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, thank you for the opportunity to address the subject on which there is absolutely no consensus. (Laughter)

Senator DURENBERGER. And that isn't just among the leaders of this country.

Senator MITCHELL. No.

Senator DURENBERGER. There is no more difficult subject, in the area of health care and the area of housing—in all of these areas. I mean, what do we do about the fact that for two generations we have raised the cost of everything we want to have, while getting somebody else to pay for it, so to speak?

And now, for a lot of people who don't have somebody to pay for it, they can't have it. That is the bottom line. We haven't talked about the self-employed. I think implicit in what Max talked about in small business is that there are a whole lot of self-employed folks out there who are paying their health insurance with after-tax dollars, while Iacocca sits there with his $450 a month fully paid plan on top of his $12 million salary.

I mean, there is a very perverse system in this country of handling subsidies. Like everybody else on this committee, I have been struggling with this for—I guess it is nine years in George's case and ten years in Max's and mine, and 12 years plus in John Heinz's case—I wonder if we aren't better off trying to deal with the issue of the subsidies before we deal with the issue of who is going to pick up the tab for all of this?

And the other issue, it strikes me, that we need to spend a little time on also is the whole issue of utilization because we can force everybody in America—and you know, I believe in the plastic card; you have heard my speech a thousand times. Everybody in America ought to have what I have—a plastic card entitling them to buy

a health plan. This is entrance into the doctor's office or the hospital.

But I just went around my State for a couple of days with Bill Roper, and he is telling everybody that Medicare went up 88 percent in the last eight years, compared to DOD which only went up 78 percent. The reality is that we are out in rural Minnesota talking about the fact that the doctors will not come to rural Minnesota because the compensation is so low and the hospitals are folding, and all this sort of thing.

And in the nature of our current subsidy system, there is just a whale of a lot of over utilization in the system. There is a whole lot—as we addressed in the hearing we had a couple of months ago—of our inability to judge outcomes. What is a good outcome, and what is not a good outcome?

So, everything that comes down the pike, we buy into, and all this sort of thing. So, while we really have a desperate need to find a way to buy the uninsured into this system, it is to me critically important that we deal with all the other cost issues at the same time and that we really strive to find ways to do something about how we use these subsidies.

John is suggesting one thing in terms of community rating as a way to spread costs; but I hope that none of us think that the issue of the uninsured is just who picks up the tab for them or how do we help buy them into Medicaid or something else because I think it is a much bigger problem which has a lot to do with the fact that we just can't get costs under control in this country.

And Max is absolutely right when he talks about small business people. I just heard last week of one business in Wadina where their health insurance went up 37 percent this year from a private insurer. Another one went up 48 percent; that is in southeastern Minnesota. And a third one went up 53 percent. And this is not "ma and pa." These are companies 75, 150, 225—maybe something like that; they have been around a while. They have been buying health insurance.

The co-pays are all in place and all the rest of that sort of thing. That is the rate. We have AIDS out there. We have the incredible problems of the chronically ill. We haven't done anything about catastrophic. Why don't we just propose we buy everybody major medical and nothing else?

I don't know whether I have talked myself through five minutes of expanding the nature of the problem here, but I know the tendency is to focus on mandated benefits and buying folks into Medicaid and things like that. Boy, we have got to deal with those costs, or we are going to sit up here voting against mandated benefits.

I was the original author of that mandated benefits bill; but when I watch those costs continuing to go up and up, going right past the ability of these businesses that I used to think should pick up the tab, it is going right past their ability to do that.

So, that is just for what it is worth. I appreciate both of these people, Mr. Chairman, by reputation and actually by their performance. They have contributed well in the past and I am sure will in the future, and I appreciate their just listening.

Senator MITCHELL. Thank you very much, Senator Durenberger. Thank you, Dr. Davis and Dr. Blendon.

The next panel includes Mr. Richard Jensen, Senior Staff Associate for Health Policy, National Governors' Association, Washington, DC; Carol M. McCarthy, President, American Hospital Association, Chicago, IL; and Carl J. Schramm, President, Health Insurance Association of America, Washington, DC

Senator HEINZ. Mr. Chairman, while these witnesses are coming forward, may I just respond to a thoughtful comment that Dave Durenberger made? I wouldn't want the record to show that I am actually pushing the idea of community rating.

I raised it as an issue because in the absence of community rating, we have a situation where the people at the highest health risk—those people who are sick—pay an extraordinary amount for their health insurance. And there is an interesting question as to who should be paying the costs of the sick. Should it just be the sick or should it be everybody?

It was very interesting to hear the discussion of how, if you do community rating, you lose the incentives for something that I think we all care about, which is health care costs management. And that is an issue which is well worth exploring, and I hope we have the time to explore it more. Thank you.

Senator MITCHELL. All right. Thank you, Senator. We will begin with you, Mr. Jensen. Welcome. We look forward to hearing from you.

STATEMENT OF RICHARD N. JENSEN, SENIOR STAFF ASSOCIATE FOR HEALTH POLICY, NATIONAL GOVERNORS' ASSOCIATION, WASHINGTON, DC

Mr. JENSEN. Thank you, Mr. Chairman; and I want to thank you for inviting the National Governors' Association to testify before you on this important issue.

I will summarize my prepared remarks and quickly tell you what the States have been doing at home to deal with the problem of the uninsured. I would like first to make the point that has already been presented, that the uninsured are not a homogeneous group. The reason for their situation differs, and the solutions to their problems, therefore, may vary.

From the States' perspective, there are already many tools out there and some potential tools to deal with the problem, and what I do in my prepared testimony is I classify them under three broad areas. The first is Medicaid expansions, the second is State-sponsored alternatives, and the third is private sector alternatives; and let me quickly mention what some of those are.

In the Medicaid program, of course, the States could always expand their eligibility limits, although often that is tied to AFDC; and, therefore, there are limits as to how far they can go with that alternative.

The focus the last couple of years of the Congressional leadership, and a great interest on the part of NGA, has been to expand the eligibility for pregnant women and children; and I might mention now that 42 States have taken up the option of providing coverage to pregnant women and infants up to 100 percent of poverty.

Another indirect way of providing for the uninsured is by paying a disproportionate share to certain provider groups. This is where,

as under Medicaid is required, States provide higher reimbursement rates to providers that are supplying services to a greater number of low income recipients and others.

And finally—and I would like to talk about this a little bit more later—but as Dr. Blendon mentioned, the very important provision that is in welfare reform and in conference now, and that is transition from welfare to work. Some of the States' sponsored alternatives have existed for years as general assistance or indigent care programs that are out there.

Another one that is much more often discussed now is financing pools. I use that term to describe a mechanism where you are trying to reduce liability across a group, where you either pool the dollars of the group even to pay for certain services. It has most often been used in the past regarding trying to pay for the costs of the uninsurable—those people with chronic conditions.

However, the discussion revolving around it now is much more concerned with using it as a tool for covering the uninsured more generally.

Finally, I mentioned the private sector alternatives; and there is a little bit of a misnomer here in that you seek remedies through the private sector, but it is not without inducements from the public sector. And here, I mean the proposals to mandate or to at least create tax incentives and disincentives that would lead to employer-sponsored coverage.

A number of States have been pursuing alternatives that have been picked from among this menu I laid out to you, and there are a number of creative and innovative pilots and now State-wide programs being pursued.

I presented in my written testimony examples of four States that are pursuing some of these options. There are many more. For the most part, they are at the pilot level, with the exception of the Massachusetts program that is going to be implemented over the next several years.

However, there are many promising aspects to these pilots. In each case of the ones I have presented as examples, they are both working with the AFDC population as it goes from transition into the work setting and also dealing more generally with the uninsured working.

In addition, I might mention a reference to Senator Durenberger's concern. All the examples I present are going to be using managed care to try to control the costs and not simply pay for the services provided.

The pitch I wanted to make in conclusion is with regard to the Medicaid transition piece in the welfare reform proposal. Although it focuses in on a small group relative to the uninsured—that is women and their families going from welfare to work—there are pieces of that provision, such as allowing Medicaid agencies to pay for alternative plans to Medicaid and allowing Medicaid agencies to charge premiums, that have ramifications for a much broader model in dealing with the uninsured problem.

And for that reason, I think it is a very exciting proposal; and I certainly hope it is approved in the conference. Thank you.

[The prepared statement of Mr. Jensen appears in the appendix.]

Senator MITCHELL. Thank you, Mr. Jensen. Dr. McCarthy, welcome. We look forward to hearing from you.

STATEMENT OF CAROL M. MC CARTHY, PH.D., J.D., PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, CHICAGO, IL

Dr. MCCARTHY. Thank you, Mr. Chairman. It is a pleasure to be here to share with you some thoughts on the issue of the extension of health insurance. As we all know and have heard already this morning, the problem is large and growing larger.

I think there are three facets that deserve some concentration. The first is, of course, the fact that, despite the heavy subsidies for private insurance and the success that has had in extending private coverage, we still have employers who don't offer health insurance coverage.

The second is the shrinking proportion of the poor that are covered by the Medicaid program, down in one decade from over 60 percent to 38 percent.

And the third part of it is at least the question about whether we ought not to be considering how we might protect the elderly and the chronically ill from the staggering costs of long-term care, an issue that we haven't brought up yet today.

I think that enduring solutions to these kinds of problems, because of the very nature of the population that is involved, require a public/private partnership. Let me briefly address the American Hospital Association's position.

In the area of the employer-provided insurance, because 53 percent of those who are uninsured have a full-time, full-year link to the work site, and another 34 percent have at least a part-time or intermittent link, we have to address the issue of employer-provided benefits.

In an ideal world, the American Hospital Association would prefer to stay with incentives only; but the world isn't ideal, and in the last decade the number of uninsured has grown by 10 million, and therefore we are in fact supporting mandated benefits.

Now, along with mandated benefits has to come some type of way to minimize the economic dislocations, to make it possible for the employer to in fact offer the benefits. For those whom, if you will, insurance in the work site won't reach, the American Hospital Association proposes that Medicaid be divided into a three-part program. The first part, acute care for the non elderly poor; the second part, acute care for the elderly and the disabled under Medicare, Part B; and the third part, long-term care insurance either funded as it is now by a Federal/State partnership or by the States.

I want to focus my comments this afternoon on that first part, which is where the Medicaid program is falling so short—the acute care for the poor under the age of 65. The Government clearly has made some progress, both in the reconciliation bills and in the catastrophic bill, in a commitment to help repair the damage that has taken place in the Medicare program, particularly since the early 1980s.

Yet severe problems remain. In the area of eligibility, for example, the mandate of coverage applies only to pregnant women and

children up to the age of one. For older children, we have to rely upon the States' having exercised their options. For all others, overall eligibility in the Medicaid program is tied to the AFDC level, and that varies from State to State; and it has been declining.

Today, in 21 States, eligibility is set at 50 percent or less than the Federal poverty level. That means that a woman with dependent children and a family of three could make as much as $4,650.00 and have no Medicaid coverage.

In the area of financing and reimbursement, unfortunately there is really in our view no answer, except that more funds would have to be put into the Medicaid program if you were to expand eligibility; and we would like to see eligibility at least set right at the outset at no less than 50 percent of Federal Poverty and then moved gradually up to reach 100 percent.

In the area of payment for health services, we have a problem, a very significant problem, where the States are running out of money trying to provide the current benefits that exist in the program.

In Illinois and in Michigan this year, for example, neither hospitals nor nursing homes have received any payment for months because the Medicaid program ran out of funds.

When those payments are set, we have to find a way for them to be both adequate and reasonable. Senator Bradley has introduced a bill that has provisions that address that matter at least for infants and children.

And last, of course, in service coverage what we have is a patchwork quilt and a real need to address the cost-effective services that are not covered, such as case management.

I want to close just with applauding, if you will, Mr. Chairman, the bill that you have introduced in the area of long-term care, which asks the right questions, which tries to provide incentives for people to take care of themselves up to the limits of their ability, which provides incentives for private sector involvement, and which also brings the public sector a little bit more into this very important area. Thank you.

[The prepared statement of Dr. McCarthy appears in the appendix.]

Senator MITCHELL. Thank you very much, Dr. McCarthy. Dr. Schramm, welcome.

STATEMENT OF CARL J. SCHRAMM, PH.D., J.D., PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

Dr. SCHRAMM. Thank you, Chairman Mitchell. I would like to begin by saying that the Health Insurance Association of America is a membership association of 360 companies; and I have spent the last two years with our members seriously considering this problem that is before the committee today.

I would like to discuss with you today our four-point program that we have engineered carefully to address the issues of all persons-35 to 38 million people—without health insurance. The fundamental premise of our proposal is that the task is made complex by

the character of the population without health insurance. One-third are below the Federal poverty level; one-third are the near poor, between 100 and 200 percent of the poverty level; and one-third are above 200 percent of the poverty level.

Eleven percent of the uninsured are self-employed and their families. Thirteen percent are half-time employees and their families; and 51 percent are full-time employees and members of their families who do not enjoy health insurance of any kind at all.

All of these factors make any single solution very difficult. Thus, we would propose to you four different approaches which may be undertaken simultaneously.

First, and here I am in concert with Dr. McCarthy, is that the public sector must be responsible for the poor, per our treaty of 1965 that established Medicare and Medicaid. We can no longer permit the erosion of Title XIX coverage, as detailed by Dr. McCarthy.

Specifically, the HIAA would like to see the following changes made in the Medicaid eligibility standards: First, eliminate the categorical restrictions on eligibility for Medicaid and Medicaid spend-down. Second, allow States to uncouple the income eligibility standards for welfare payments from eligibility for Medicaid. Third, eliminate eligibility restrictions, such as limits on the hours of work, for those individuals and families who may be employed but still remain below the eligibility income standard.

Finally, require all States to have a medically needy program and to allow low income individuals to buy into Medicaid, preferably through an income related premium.

This committee has before it several bills which would be a reasonable first step along this road, albeit incremental, to assure everyone equal availability of care. S. 2122, for example, The Medicaid Infant Mortality Amendments of 1988, sponsored by Senator Bradley and cosponsored by seven other members of the committee, deserves early consideration and has our full support.

I believe there are other bills before you which also deserve consideration, sponsored by Senators Durenberger and Chafee, which also address these issues in whole or in part.

The second touchstone of our program would be allow insurers to offer more affordable coverage, including prototype plans. ERISA preemption of State-mandated benefits could be extended to insured employee plans, as well as self-insured plans, so that insurers can design less expensive benefit packages for small businesses.

HIAA will support statutory changes to enable insurers to make lower cost prototype plans available. All such plans would be actuarily equivalent in value and include basic inpatient and outpatient physician, hospital, and diagnostic services. Additional services, such as dental coverage and mental health, would be offered in some prototypes in exchange for higher copayments. In all prototypes, managed care features would be permitted and encouraged.

The third building block would be to make coverage available to all Americans. This is true even for those whom insurers might normally decline due to existing high-cost medical or occupational conditions. There are two components of this proposal to consider here: uninsurable individuals and uninsurable employer groups.

We continue to seek Federal legislation encouraging all States to enact qualified State pools for medically uninsurable individuals. Such pools have already been adopted in 15 States.

To ensure access to group coverage for all employees, a nonprofit organization should be established to reinsure uninsurable employer groups.

Employers would access either directly or through insurance companies. Losses incurred by the reinsurance corporation could be financed entirely by the private sector if shared on a fair basis by all competitors in the small group market and all larger health plans whether insured or self-insured.

Finally, we believe that small businesses must be given a greater incentive to provide coverage for their employees. Self-employed individuals should get 100 percent deduction for their health insurance protection, as long as they provide equal coverage for all their employees.

It is our belief that this four-point plan provides a blueprint for a truly comprehensive approach to the problem of uninsured citizens. The plan stresses the sharing of responsibility between the private and public sectors. We offer no magic bullet or free lunch; it is difficult work, and we want to work with the Government to get the job done. Thank you.

[The prepared statement of Dr. Schramm appears in the appendix.]

Senator MITCHELL. Thank you very much, Dr. Schramm, for a very specific proposal. We will begin with questioning by Senator Heinz.

Senator HEINZ. Mr. Chairman, thank you very much. I don't know who to ask this question to, but Karen Davis presented us with some cost estimates for her mandated coverage legislation; and I believe she mentioned that it would cost $10 billion.

She described a program of mandated coverage, which included what she described as "a modest benefit package" and I think fairly good coverage for children and prenatal care. What do we know, if anything, about the costs of such a mandated employer-based approach? How much more would employers be required to spend annually? And since all of you have advocated an approach something like that, maybe you have done some research on it.

Dr. McCarthy? Dr. Schramm?

Dr. MCCARTHY. Let me approach it this way. Clearly, any of the approaches' cost depends upon the specific benefits that are included and the actuarial estimates of the health of the population being covered. The $1,000 per employee approach——

Senator HEINZ. I have heard that $1,000; is that an average employee with a spouse and one or two dependents, or is that a single person?

Dr. MCCARTHY. That, I am assuming, is a per-employee charge that Dr. Davis has put in front of us.

Senator HEINZ. Now, before you go any further, Dr. Schramm, what can you get if you are a small employer? What kind of coverage can you get for a family with two children for $1,000?

Dr. SCHRAMM. Not much, Senator Heinz. I would use your question as an opportunity to suggest that I am concerned that the figures you heard earlier may be underestimates. Our sense of what it

would cost just to build the minimum part of Title XIX, the Medicaid part, that I have outlined would run between $6 and $10 billion.

Our estimate for family coverage for a very modest benefit package, which is substantially less than the comprehensive package contemplated by the Kennedy bill, in 1988 would run about $780 for single coverage, $2,100 for a family, or roughly $1,500 as a composite per employee cost.

So, I think our estimates run significantly larger than those you heard earlier for what we believe, from our analysis, to be a more modest package of benefits.

Dr. MCCARTHY. Senator Heinz, as I recall, Dr. Davis did indicate that that $1,000 was an average; she looked at both individual and then family and came up with the average cost.

Senator HEINZ. All right. Now, Dr. McCarthy, you represent the hospitals?

Dr. MCCARTHY. Yes.

Senator HEINZ. Now, let's assume that we enacted a very generous employer mandate; and I am not talking about Medicaid for the moment, just that we did a very generous employer mandate that cost a good deal more than the $1,500 per employee or $1,200 per employee that Dr. Schramm just described.

To what extent would that reduce the amount of uncompensated care that hospitals currently now have to absorb?

Dr. MCCARTHY. Again, you wouldn't even need to do a very expensive program, but any amount of money that would be put toward giving people the dignity of having insurance to help pay for their costs would, in fact, impact on the significant losses that the hospital has to sustain.

Senator HEINZ. I understand that every little bit helps, but that is not my question.

Dr. MCCARTHY. Right now, we are spending $7 billion in unsponsored care in hospitals. That is charity care, less the payments that governments make—in particular local and State governments—to help offset the costs.

Senator HEINZ. My question is: If you took this population of people who have a sufficient tangency to the work force and you mandated health insurance coverage, you would certainly get a plus; but you yourself and others have made the point today that dwindling Medicaid coverage, the increase in deductibles and copays for current employer health insurance, that uncompensated long-term care—all of those and others comprise the uncompensated care burden that hospitals must bear.

My question, therefore, is quite relevant. There is a substantial argument—a good argument—that one of the reasons that we need to do something with employers is that, if we don't do that, the burden on hospitals will become more and more unbearable; and there will be some kind of terrible implosion of the health care system.

Indeed, in my State of Pennsylvania, emergency rooms are closing down; maternity wards are closing down. The question is: How much of a contribution to alleviating that problem quantitatively will what you advocate in the way of employer-paid health insurance really make?

It is not an academic question. I am trying to get an answer that is fairly clear and fairly specific.

Dr. McCarthy. The employed comprise about two-thirds; those with a link to the work site are 50 percent full time, another——

Senator Heinz. We know those statistics.

Dr. McCarthy. So, if you play that off, if you say that the unpaid bill in hospitals is $7 billion a year and if two-thirds of that could be taken care of more or less by insuring people in the work site——

Senator Heinz. That is a rule of thumb, but the problem I have is—and I have to stop—we don't know that that rule of thumb is a valid rule of thumb because people who are younger, generally speaking, don't need as much in the way of health care services as people who are older. The older you get, when you have an illness, the sicker you tend to get.

So, chances are it is not as simple as that, even though we all wish it was. Thank you very much, Mr. Chairman.

Senator Mitchell. Thank you, Senator Heinz. In her testimony earlier today, Dr. Davis estimated that if health insurance by employers were mandated, there would either be no effect on employment or a net increase in employment.

I would like to ask each of you whether or not you agree with that statement; and if you care to respond in writing, you may do that. And I would like to hear the reasons from those who disagree. Mr. Jensen?

Mr. Jensen. First, if I might mention something, I may have misled Senator Heinz earlier. He commented that we were all in favor of mandates, and I have to say that I was commenting on it as an option out there for the States, not necessarily advocating it; in fact, I am not.

Senator Mitchell. All right.

Mr. Jensen. I found Dr. Davis' argument very interesting. I have never heard that argument before, to be quite frank. I have not myself done a lot of research on it; but in relying on people like the Congressional Budget Office and others, I have always believed that there would be a slight drop in employment, although I don't think it is as extreme as sometimes is portrayed.

Senator Mitchell. All right. Dr. McCarthy?

Dr. McCarthy. The American Hospital Association hasn't done an econometric model such as that which Dr. Davis set forth for you. So, I am afraid that we have nothing that we could submit in the way of hard facts. I will, however, ask and see if there is something we could put at your disposal.

Senator Mitchell. Fine. Dr. Schramm?

Dr. Schramm. Mr. Chairman, this in part answers a question I didn't get to with Senator Heinz. We estimate that the mandated provisions of the Kennedy bill might cost between $27 and $32 billion to private sector employers.

Now since, the early days of minimum wage debates before the Congress, there has been a continuous and unsettled debate as to the disemployment effect. It is our guess that there would be significant disemployment effects, but I don't want to get into an exact numerical estimation.

Senator MITCHELL. All right. Would you provide us with the best written analysis you are able to come up with on that subject?

Dr. SCHRAMM. Yes, Mr. Chairman.

[The information appears in the appendix.]

Dr. SCHRAMM. I would just say two additional things. One is that I believe it was Dr. Davis' testimony, and we want to check with her, that her testimony before Senator Kennedy stated there would be small, perhaps insignificant disemployment effects connected to the Kennedy bill because the infusion of funds from the newly insured would result in the creation of more jobs in the health sector. Mr. Chairman, I am not sure that in this society we should ever seek a net washout in terms of the disemployment effect because there will be more workers employed in the health delivery area. I think as a matter of public policy we spend plenty of money in that area and have plenty of people engaged in the area currently. It is really a distribution question that we are talking about, and I am not sure it is the wisest thing to put more people to work in this sector.

Senator MITCHELL. Thank you, Dr. Schramm. Mr. Jensen, both Dr. McCarthy and Dr. Schramm suggested the expansion of Medicaid. Of course, as you know—and you are very concerned about that—that is a Federal and State participating program; and most of what we hear from State governments is the difficulty of dealing with the problem as it now exists.

As a representative of the governors, do you favor mandated expansion of Medicaid to deal with the problems, as has been suggested by both Dr. McCarthy and Dr. Schramm?

Mr. JENSEN. No. The National Governors' Association does not support any of these proposals. We are on the record—and you have heard this from previous hearings, Mr. Chairman—that we do endorse the proposal to expand at State option Medicaid eligibility to all children up to age 18 up to 100 percent of poverty.

Right now, as you know, we are incrementally moving in that direction. It gets back to tough decisions, but each State feels that it has budgetary constraints to deal with each year; and particularly with the number of mandates and requirements coming down in the next two years in the program, it is not something the governors are going to be supporting any time soon.

Senator MITCHELL. Dr. Schramm, the fourth of your four points was to provide self-employed persons with a 100 percent deduction for health insurance costs. How do you propose to pay for that?

Dr. SCHRAMM. Senator, I am not sure I have a direct proposal. Some of the spending that we would ask for in the area of Title XIX, for example, we would hope would be recovered in terms of savings in the area, for example, of uncompensated care.

There are direct payments for that now in place, and we would hope that there would be net savings both publicly and privately that might be redirected in this way.

Senator MITCHELL. I would appreciate it, if you have not done so in your written statement, if you would provide us in writing with your estimate of what that would cost and the specific means by which you propose to pay for it.

Dr. SCHRAMM. All right. Thank you.

[The information follows:]

The cost of giving self-employed taxpayers a 100 percent deduction for their health insurance costs in lieu of the current twenty-five percent would be $.5 billion in 1988, $.9 billion in 1989, $1.3 billion in 1990, and $1.6 billion in 1991.

Our specific recommendation for replacing these lost revenues is to increase the excise tax on cigarettes.

Senator MITCHELL. Thank you very much. Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, I haven't got the figures for that, but I do have the proposal; and it is financed by the changing the way we handle the subsidy that currently exists. Instead of having the current subsidy in which the employer gets a deduction and the employees do not get taxed on the value of the expenditure, you give everyone a deduction against their tax liability for premiums paid either by a third party or by themselves.

I don't know whether it is a wash; maybe somebody in the audience who is familiar with my bill knows whether it is a wash or not. But you can make it a wash if you just cap the amount of the monthly subsidy.

When we used to talk about capping in this committee, it was $100 a month for a single person and $250 or something for a family plan, or something like that. But that is the mechanical way to implement Dr. Schramm's suggestion.

Then, the self-employed, the small business people, the big business people—everybody gets treated the same. People will still have different levels of subsidy depending on how much an employer can afford or they can afford to put in, but the tax treatment—the public treatment—of everyone who works will be essentially the same.

I compliment you, Carl, and the association for that recommendation.

I need to ask all three of you about this notion of buying into Medicaid, and maybe somebody can supplement the record with the figures. But I think in my State of Minnesota, which is generous on the benefits side and not very generous on the payment side—and I hope isn't typical of the rest of the country; maybe the rest of the country and the other States are more generous—but I am really chary about buying any more people into the Medicaid program or the concomitant medical assistance.

I go through my State in the rural areas, and I know the State is paying something like 45 percent of charges and about 65 to 70 percent of costs. Now, I don't want to buy any more people into that kind of a system because those are the people who don't have voices; and they always get beat up in State legislatures by folks with more powerful voices.

So, to ask more people to go into that system doesn't make a lot of sense to me. Now, if on the other hand, rather than saying we ought to buy everybody into Medicaid, we would require the Medicaid system to supplement in some way the contributions made by employers, now we might be getting somewhere. And maybe implicit in some of these recommendations you have made is this notion.

When we launched the Medicare experiments with competitive medical plans, the notion was that Medicare would go out there and supplement somebody's choice of health plans with a flat dollar amount; and then, hopefully, employers would also come

along and do the same thing for their retirees. I would guess we could do the same thing for lower income people, particularly now that we are doing welfare reform and we are talking about earning supplement.

Maybe we could have a system in which employers could pay part of the premium and people would pay part of the premium; and there would be some kind of a sliding scale supplement by "the Medicaid system" or whatever it is. I don't know where to start by way of getting a response.

Mr. JENSEN. Senator Durenberger, as a matter of fact, although the National Governors' Association doesn't have a particular policy one way or the other on this proposal, in my testimony I mention a few States and the pilots they are running.

In the States of Maine and Michigan, they are in effect putting into place an employer supplement. And in Washington, what you have is basically a buy-in option. Obviously, all these things are just now getting set up.

I can comment on the pros and cons of each. What a buy-in presents—and I really need to make some reference to Med-America here because I am familiar with that proposal—is that it lends a lot of flexibility to the State to bring people into the system and in terms of how to structure the program. I think those are some of the positive sides of it, and we don't have all the answers yet.

I think the State of Washington is going to find out exactly how positive it is. One of the concerns I see, though—and I think you are implying it from your question—is that it is a matter of are we going to deal with this problem from the bottom up first or from the top down, bringing in the employers first rather than the public sector, and where does the balance really lie?

The question that is raised with the buy-in, as you implied, is that maybe that is taking the private sector off the hook and that, in some way, especially if you go up to 200 percent of poverty—and I know States have expressed this concern—is going to put a greater burden on the States. In fact, when you are talking about charges being low now, maybe they will end up lower when you have a much bigger program.

I think that the welfare reform proposal, as I said earlier, is a nice model to be looking towards—special case model that might be expanded out to the rest of the uninsured population; and that is why we are certainly endorsing its passage at this time, primarily for the transition, of course, more broadly.

That is a long way of saying I don't have exact answers now, but it is interesting that you bring up that question because it is exactly what States are trying to deal with in their pilot projects. And in fact, different States have chosen to go in different directions with that issue.

Senator MITCHELL. Thank you, Senator Durenberger. Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman. A question for Dr. Schramm. In your testimony on page 4, you state that "the public sector must be responsible for the poor." And then on page 6, you state that "Federal legislation encourages all states to enact a qualified State pool for medically uninsurable individuals."

This question may have been asked before I came back in, but don't you think there ought to be some kind of a shared responsibility between the public and the private sectors. Aren't you suggesting you want all the good risks and you want the Government to take all the hard risks?

Dr. SCHRAMM. Senator, I think basically our proposal is as follows. It is not a question of the goodness or badness of the risk; it is the question, as was conceived by the Congress in 1965, as to who can afford and who can pay. There will never be a market on the private side, either commercially or in Blue Cross, for people who cannot pay a monthly premium or who are uninsurable.

Our premise was that the program, Title XIX, Medicaid, as Senator Durenberger pointed out, varies enormously from place to place and needs enhancements and needs people to advocate on its behalf a decent program—a public insurance program.

As regards the question of people who are medically uninsurable, we do on page 6 advocate a State role only insofar as setting up the program. We need a State law, as 15 States have done it, whereby we can, at 150 percent of the average individual premium, get a product to people who otherwise are denied coverage in the individual insurance market and, in some cases, in the group market, to make sure they can at least buy a minimum benefit package in the private market.

As it stands now, many people who are medically uninsurable, but who have plenty in the way of means to buy a product, are denied access to that market all together; about 1.8 million people in the United States are so situated. And that is what our reference is on page 6.

Senator ROCKEFELLER. All right. Also, to you, Dr. Schramm, and actually to all three of you: risk pools. Mr. Jensen said risk pools are a way that a State can provide health insurance for people with chronic medical conditions or low income uninsured individuals. You said that on page 5. You state that "the Sate appropriates funds or seeks other funding sources to pay the costs not covered by premium contributions."

What types of other funding sources have been used? And do you have your own thoughts, any of you, on that?

Dr. SCHRAMM. Senator, of the 15 existing plans for the uninsured, I believe all but one lose money, even at 150 or 200 percent of the average prevailing individual premium. In one State, this fund is back stopped by general revenue; that is in the State of Illinois. And it seems to me that that is one way to travel.

In the other States, the loss is basically made up by a subsidy from other people who buy insurance in group and individual lines. What essentially happens is that we see the insurance companies operate a public taxing mechanism by implication.

Senator ROCKEFELLER. All right. What about you, Mr. Jensen?

Mr. JENSEN. Yes. Also in my testimony, I tried to make a distinction between risk pools for the uninsurable and the more general concept of financial pools for the uninsured. Really, the sources of income could vary. They could be general revenues; and some States have used assessments against hospitals. One model, of course, with the uninsurable or dealing with trying to subsidize

employers is you get the employer's contribution. but the State is involved as well; and you might think of that as a pool.

The word "pool" has many definitions that are being thrown around these days, and it is important to realize exactly what the purpose is and then think about sources of payment and so forth.

Dr. McCARTHY. I would only indicate that in these broader pools, at times with the workers, in fact, we have used a payroll tax—the broadest possible base. At times, in fact, insurers have been asked for an extra subsidy; and at times, the State has subsidized the pool.

This is not for the uninsurable or difficult to insure, but these broader based pools, as you described for those of lower income.

Senator ROCKEFELLER. There are 14 States that are now doing that?

Dr. McCARTHY. That is 14 States doing the pools for the medically uninsurable—people who have conditions that are such that no insurance company would like to cover them. They are a very bad medical risk; they can't buy insurance. Those are the 14 States doing that.

Other States have proposed a pool-type arrangement to take care of people who have no insurance; and that is part of the bill in Massachusetts and part of Congressman Stark's bill as well.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Senator MITCHELL. I must say that one of the reasons I asked for this hearing was I felt that the importance of the problem was exceeded only by the difficulty in solving it; and nothing we have heard today has altered my view. In fact, it has all confirmed it.

Senator Chafee, maybe you can come up with a consensus solution?

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Oh, I have already done that, Mr. Chairman. (Laughter)

Senator MITCHELL. Then, we welcome you even more than we usually do.

Senator CHAFEE. Thank you for your generosity. (Laughter)

We seem to be spending a lot of time together. We just were on the floor until 2:00 on endangered species, and now here. I have a Med-America proposal which I seek every opportunity to encourage this committee to pay attention to, and it is an extension of the Medicaid.

It provides for a buy-in of Medicaid, and Dr. Schramm touched on it in his testimony. So, I hope we can get somewhere with that.

Let me ask you a question that perhaps has been touched on; and this, I believe, Dr. McCarthy or probably all of you can help on. What about the doctor situation if we get this? Do we have to pay attention to educating more doctors to make them available? I am not worried about there not being enough doctors eventually or that there are not enough doctors in the country; but the question is: Should we think of that side of the equation also?

Dr. McCARTHY. I think you have to look at the amount of payment that is involved here to the professionals, if you are really

looking to ensuring access to care. We are having some significant problems with physician coverage, for example, of the Medicaid population right now in certain parts of the country because the Medicaid rates of payment are so very low.

We have, for example, for hospitals the legal provision in the law that says that payments under the Medicaid program must be reasonably related to the cost of care; and we have a good deal of regulation that talks about how to cap it. But we have nothing in regulation that talks about floors, and that is why Senator Bradley's bill has some very interesting inclusions that would put a floor on how low you can go.

If what we are really interested in doing is making sure that people receive services, then we really do have to look to see that the payment is at least reasonably related to the cost of delivering their care.

Mr. JENSEN. I would disagree a little bit with that. I think the Boren amendment that talks about economically and efficiently run facilities is a floor, in fact; the courts have said it is a floor. It is a growing floor.

If I can take a specific case example, too, that I am concerned about that has been brought up in the Bradley bill, it has to do with OB-GYNs and their availability. There is a tremendous supply problem for the Medicaid population with this specialty, and fees are undoubtedly one issue there; but I would hope the subcommittee, as it considers that issue, thinks about some of the other issues that are affecting the availability of OB-GYNs and doesn't simply require Medicaid to raise fees and not do anything else because just raising fees is not going to bring doctors into the Medicaid program.

Senator CHAFEE. Is this because of the liability insurance?

Mr. JENSEN. Liability primarily. In some parts of the country, regardless whether they are on Medicaid or not, women cannot get services, particularly obstetrical services. And while I understand that the fees are a problem, it is more comprehensive than that. And simply raising fees is not going to resolve the problem.

Dr. SCHRAMM. Senator, as regards your question on the supply of physicians, it would be my personal sense that that is the last area you want to pay attention to—the production of new physicians. We have 40 percent more physicians practicing in 1988 than we had in 1980. Real relative income of physicians has gone up steadily through that period.

At the same time, we have more units being delivered in terms of total units of physician time in a steady-state population. I think all that points as incontrovertible evidence to two conclusions. One is that we have a distribution problem that has grown worse and worse over the period. Poor people don't get to the doctors although many more doctors are seeing many more people. That is point one.

The second thing is that it points to the fallacy of applying normal economics-of believing that the normal laws of supply and demand apply here. If we push more physicians into the area or into the population, we will have more problems of redistribution. You will have to saturate Boston such that one in six people is a physician before you will get a physician into rural Massachusetts.

Creating more doctors is not the answer. The question is getting the right incentives or regulation to put doctors in areas where we need doctors.

Senator CHAFEE. Thank you, Mr. Chairman. I just want to note that I saw an article about the decline in the public health service—the medical service corps of doctors—who are willing to go into the low income areas; and I think that is a matter for concern. Thank you, Mr. Chairman.

Senator MITCHELL. Thank you, Senator Chafee. We had better give the AMA a chance to comment on Dr. Schramm's last statement. (Laughter)

Senator MITCHELL. Thank you very much, Dr. McCarthy and gentlemen. Your testimony is very helpful to us. The next panel includes William S. Hoffman, Ph.D., Director, Social Security Department, International Union of United Auto Workers, Detroit, Michigan; T. Peter Ruane, Ph.D., Chairman, Small Business Legislative Counsel, Task Force on Mandated Benefits, Alexandria, Virginia; and Willis B. Goldbeck, President, Washington Business Group on Health, Washington, DC .

Senator DURENBERGER. Mr. Chairman, as these witnesses are being seated, I would just like to take 30 seconds to expand on both John's question and Carl Schramm's answer.

Someday I am going to bring my chart of the AAPCC—you know, the average Medicare payments—and this distributional problem is simply a matter of not paying people to be in the place where you want them. The AAPCC currently in Miami is like $363 a month, and in my home town, which is St. Cloud, Minnesota—50,000 plus or maybe 100,000 people in that county—it is approximately $155.

You know, there are segments of this country where there is so much money—and Miami is one of them—going in to doctors, of course, every doctor is going to want to go to Miami; and they aren't going to want to come to St. Cloud. So, the answer is a distributional answer, not adding more doctors because they will end up—as Carl said—going to Miami because that is where the money happens to be.

Senator MITCHELL. Thank you very much, Senator Durenberger. Dr. Hoffman, we will begin with you. Welcome; we look forward to hearing from you and the other gentlemen on the panel.

STATEMENT OF WILLIAM S. HOFFMAN, PH.D., DIRECTOR, SOCIAL SECURITY DEPARTMENT, INTERNATIONAL UNION OF UNITED AUTO WORKERS, DETROIT, MI., ACCOMPANIED BY: ALAN REUTHER, ASSOCIATE GENERAL COUNSEL, UNITED AUTOMOBILE, AEROSPACE, AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, UNITED AUTO WORKERS, WASHINGTON, DC

Dr. HOFFMAN. Thank you. I am William Hoffman. I represent the UAW; with me today is Alan Reuther, Associate General Counsel. I appear before you on behalf of 1.5 million active and retired members of the UAW and their families.

We appreciate this opportunity to present our views on the very important issue of people who don't have coverage for health insurance. You have heard the statistics of the 37 million Americans—

approximately 16 percent of the population—who lack public or private coverage.

Significantly, about three-quarters of these people without health insurance are working men and women and their dependents. In addition, there is a significant problem with substantial cutbacks in the Medicaid program.

In our view it is simply unacceptable for a nation that has consistently been a world leader in advancing modern medicine to allow so many people to be denied access to adequate health care services. Too often individuals are forced to postpone or do without needed medical care because limited family income must be used for food, housing, or other basic needs.

In addition, the lack of health insurance coverage ultimately increases total health expenditures because individuals are forced to rely on hospitals, particularly public hospital emergency rooms, for medical treatment, instead of using preventive and other types of more cost-effective medical services.

At the present time, uninsured persons usually wind up being treated as uncompensated care cases by hospitals and other health care providers. The cost of providing this care, which is estimated at about $8 billion a year, is not fully absorbed by hospitals and other providers. Instead, it is passed on to other private payors, mostly to unions and employers who are providing health care protection.

The UAW is also concerned about situations where a worker does not receive any health insurance coverage from his or her own employer but instead is covered by their spouse's employer-sponsored health insurance. In such cases, the health care costs associated with the worker are directly shifted from one employer to another. This type of cross-subsidization between employers is unfair and inefficient.

Mr. Chairman, the array of difficult and interrelated problems that you have been taking a lead in holding hearings on can only be addressed, in our opinion, ultimately by the enactment of a universal and comprehensive national health insurance plan.

The UAW has historically been a leader in the fight for a national health insurance program. We remain committed to this goal and are confident that it will be achieved.

We believe that it would be worthwhile to explore whether comprehensive health insurance benefits can be provided to all Americans through a program that would have Federal standards but which would be implemented and administered by the States.

We commend Governor Dukakis for his leadership in enacting the Massachusetts Universal Health Care Bill. This landmark legislation provides universal access to health care insurance for all residents of Massachusetts.

We urge similar action in other States. Ultimately, however, we believe that such a program needs to be implemented on a national level. Although our support for a national health security program remains unchanged, we recognize that there is an opportunity at present to encourage legislative initiatives that will provide greater access to health care for millions of Americans.

Senator Kennedy has introduced the Minimum Health Benefits for All Workers Act of 1987, which would require all employers, as

a condition of doing business, to provide their workers and their families with at least a minimum level of health insurance benefits. More recently, Representative Stark has proposed the Employee Health Benefits Improvement Act of 1988, which would basically accomplish the same objectives by imposing an excise tax on any employer who fails to provide a minimum level of health insurance benefits to their workers and their families.

We strongly support the basic thrust of these bills. Regardless of the enforcement mechanism, we believe all employers should be required either to provide a minimum level of health insurance benefits directly to their employees and their families, or to pay a tax to the Government to cover the cost of providing these health insurance benefits through a Government-sponsored program.

There are two basic objectives to such initiatives. The most important is to significantly improve access to needed health care services and thus improve the health of millions of Americans. Second, through such action we would reduce most of the inefficient and unfair cost shifting that takes place in our present health care system.

Mr. Chairman, we appreciate this opportunity to appear before you today. We realize others have taken some objection to the kind of mandating approach outlined here; but clearly, there is ample precedent for the Federal Government to take such action. Our society has already mandated that employers provide or pay a minimum wage, contribute to minimum retirement income, disability, and basic protection against loss of income due to layoffs through Social Security and unemployment.

We think that this would be an additional step in the right direction. Thank you very much.

[The prepared statement of Dr. Hoffman appears in the appendix.]

Senator MITCHELL. Thank you, Dr. Hoffman.

We are pleased to be joined now by Senator Riegle, who was detained at another hearing earlier; and I would like to call on him to see if he has any opening statement he wishes to make at this time. Senator Riegle?

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN

Senator RIEGLE. Thank you, Mr. Chairman. I will be very brief. First, I want to commend you for holding the hearings, and I want to thank the witnesses that have appeared today.

I quickly want to acknowledge Dr. Hoffman for his comments and for the leadership of the UAW over a long number of years in this area.

Many of us have been active in this area. I introduced the first bill that I have tried to enact on the uninsured back in 1982, and that was directly principally at unemployed workers or workers who had lost their jobs. And now, of course with later versions, we have widened that out to a comprehensive plan.

I think it is essential that we structure an insurance system where everybody in this country is covered, and I mean everybody—no one is left out. Now, it has to be financially sound, and

there will be costs involved. I think if we structure this carefully and we use the States in an important role, such as we are seeing now in Massachusetts, I think we can get this done.

If we are going to be productive as a nation and really excel in the way we are going to have to in this new world economy, people have to be well and healthy and in a position to do for themselves and for all of us what they can.

So, I very much appreciate your statement, and I am anxious to hear from the others. Thank you, Mr. Chairman.

Senator MITCHELL. Thank you, Senator Riegle.

Senator RIEGLE. I would like to have my whole statement, if I may, be made part of the record.

Senator MITCHELL. That will be done. Dr. Ruane, welcome. We look forward to hearing from you.

STATEMENT OF T. PETER RUANE, PH.D., CHAIRMAN, SMALL BUSINESS LEGISLATIVE COUNCIL, TASK FORCE ON MANDATED BENEFITS, ALEXANDRIA, VA

Dr. RUANE. Thank you, Mr. Chairman, members of the committee. First, I would like to thank you for the opportunity to join you this afternoon to present the views of the Small Business Legislative Council. The SBLC is a permanent coalition of some 90 trade associations representing the full spectrum of U.S. business, ranging from transportation to construction to retail to a wide range of service activities.

This afternoon, I would like to address just three items in my statement. I will summarize the statement that has been provided to the committee.

Those three items are, first, to share with you the results of several surveys that four of our member associations have made; second, to share with you some of the concerns we have about one of the principal bills that is the general subject of this hearing today; and third, to share with you some of our thoughts on the future of this type of legislation as it affects small business.

In our statement, we present the summary of an association in the retail industry, two in the distribution industry, and one in light manufacturing. I call your attention to the specifics of those surveys, and I think you will find, without qualification, that all these surveys point up one bold fact: the industries represented by those surveys and the 90 trade groups represented within SBLC are unanimously opposed to the mandating of any programs such as we are talking about here today.

The reasons for those positions are quite clear also. Small businesses experience high turnover, particularly in the retail service businesses. Profit margins are generally low, and the question of affordability has not been adequately addressed in any of the hearings of which we are aware nor in the research that has been shared up to this date.

Our view specifically on the leading proposal with which many of the members here are intimately familiar, S. 1265, is that we find this proposal not to be acceptable to our members; and as evidence of that widespread feeling within the small business community,

we circulated a petition to all 90 trade groups. I just brought a small sample of these petitions here with me today.

We have received 13,000 petitions from business owners all across the country. In fact, we had them in our car coming here. We decided, wisely I think, that if we had transported them down the halls here, our own insurance would have gone up for a large claim.

It would stack up six feet high, Mr. Chairman and members of the committee. We feel these petitions are quite representative of the average point of view of the small business owner out there in America today.

We also would like to address the general philosophy that undergirds these proposals. We feel, once again, it is simply a matter of the Federal Government interfering in the day-to-day operations of the small business owner. It limits the flexibility that a small business person has to deal with the benefit package for each and any one of their employees.

Second, we again, addressing the point of affordability, have yet to see any compelling evidence that proves to us or any of the associations we represent, that the average small business person can afford the mandating of such benefits.

We believe the cost estimates to which some of the questions were addressed earlier this afternoon, have been underestimated. The job loss impact, which we would be glad to comment on later, has not been fully identified. We believe there would be a net negative job loss if these proposals were implemented.

Finally, Mr. Chairman and members of the committee, our outlook for this type of legislation and issues related to it is that we cannot provide any alternatives at this point. We have addressed in our statement some of the points made on some of the recent questions in the last 30 minutes about the issue of tax deductions.

We would favor tax deductions to small business owners for incentives to provide insurance to all their employees. We would be in favor of full deductibility for those who are self-employed.

Second, we believe there needs to be more attention to the whole issue of health care cost containment—again, some comments made by some members of the committee earlier this afternoon referred to this concern. We are aware of the fact that this particular committee, Mr. Chairman, held hearings recently on this very issue; and we would urge the Congress and this committee in particular, to address the whole issue of health care cost containment.

And finally, we believe that this issue is part of a general pattern of micro management that is being forced on the small business community today. It is something that, quite simply stated, one might easily summarize as a hassle factor, a factor that we believe in this Congress and in the next Congress in particular is going to become of more increasing concern as we believe it is a major deterrent to entrepreneurism in America today. Thank you.

[The prepared statement of Dr. Ruane appears in the appendix.]

Senator MITCHELL. Thank you, Dr. Ruane. Mr. Goldbeck, welcome.

STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH, WASHINGTON, DC

Mr. GOLDBECK. Thank you, Mr. Chairman. It is a pleasure to be here. I am the President of the Washington Business Group on Health, which is an organization comprised of very large employers throughout the United States.

It is our belief that the issue of the uninsured must be viewed within the context of, number one, establishing policy for the 1990s and the climate socially, economically, and culturally that will exist in the 1990s, rather than being bound by the conditions that existed in this country perhaps somewhat more wistfully in the 1970s and early 1980s.

The reality is that the U.S. standard of living, when measured by access to any needed social service, has substantially decreased in recent years, whether you measure that in education and literacy, housing and homeless, health or the absence of health insurance. Those are the realities.

It was interesting to hear that Senator Bentsen was speaking about kids; Senator Chafee was speaking about kids. The reality is that in fact U.S. kids are increasingly an endangered species, by any measure of statistics that you would like to find for the United States today.

Prenatal care is but one example of the kind of an insurance plan that ought to have been in every insurance policy in America. It is proven to be cost efficacious, and the absence of prenatal care coverage today is one of the reasons why health care expenditures are unnecessarily high and monies are wasted on things that otherwise would have been well applied to needed services.

The nature of employment in America has changed dramatically in the last few years to increasingly small business, low pay, low benefit jobs. However, it is also true that better than 50 percent of the small businesses in America, based on the Small Business Administration, provide health insurance for their workers.

Therefore, it is hard for me to come to grips with the terms that automatically small business can't afford health insurance. Somehow or other, 50 percent of them or more are affording it; and that would seem to counter the claim that, because they are small, you can't afford it.

One of the problems that employers face in dealing with these issues is that, in fact, we have had a litany of new taxes called other things, called "Medicaid secondary payor," called "Section 89," called "COBRA." I could do this for another ten minutes; this gets pretty boring.

The reality is that, when you hear across the room saying, as far as I know is more than adequately qualified to say that the mandate would represent $25 billion or so, that is a tax. More and more, major employers are accepting the idea that these issues have to be addressed in a forthright fashion; and if it is necessary to tax America to provide the services America wants, that is something we have to face up to.

It doesn't mean it is necessarily desired, but it has to be faced up to. It is incomprehensible to me to think that this is going to be a budget neutral issue. We are not going to go from where we are

with the X number of millions uninsured, with Medicaid in abject failure in terms of covering less than 50 percent of its target population, with Medicare increasingly bankrupt and not even touching the long-term care area—with which you are so familiar.

We are not going to resolve those issues and end up in a benign neutrality. Health care in America is not neutral, nor will the financing of care be neutral.

We also do support the 100 percent deduction for the self-employed. We support the concept of a national Medicaid eligibility standard and the buy-in approach. I haven't an idea as to whether it should be 100 to 200 percent or 100 to 150; those are technical issues to be resolved in the relationship of the dollars outlaid to the proportion of the population you want to cover; but it is clearly a process that can work.

And yes, it could be combined with an employer-paid approach; there is no reason why not to. I think Senator Durenberger's point is an important one; but the more you brought workers into Medicaid, the more in fact that program would have voices. It wouldn't be more voiceless people; it would be more people with voices, and that should be considered as well.

One thing that I have not heard much of in this discussion today is the issue of appropriateness. When we look for money, we not only have to look for the printing of new ones; we can look for the appropriate allocation of existing funds.

All you have to do is look at the relationship between Boston and New Haven—a classic set of studies—presented to the Congress over and over again that shows that supremely high quality of care in New Haven costs a fraction of the perhaps equally high quality of care, but certainly no better care, in Boston.

We have a choice as a Nation. We can determine, and you can take the leadership role in saying, that this Nation will have the New Haven model economically speaking. We have the waste in malpractice; we have the excess in the bypass surgery that was just redone, restudied, and reaffirmed again and again and again in recent weeks.

So, there is no reason why we can't establish a system where the Government and the employers and the unions become aggressive purchasers of care by quality specifications with demands for appropriateness and accountability of the providers along both price and quality lines.

Yes, this will mean some limitation in choice. It will mean people's choices are limited from a complete search to a morass with no identifiers to a more guided search through a few well established, highly qualified, and measurable and accountable providers for the specific services which are in need at that moment.

No, most big employers do not want mandates, but it is also true that more and more dislike being taxed to pay for the care used by employees of other employers who also simply chose to gain an economic advantage by providing no insurance or going through the route of having a big company create the subsidy for a small company. I might add that because the Washington Group indeed is a very small employer. We don't like that any more than a big company likes it.

[The prepared statement of Mr. Goldbeck appears in the appendix.]

Senator MITCHELL. Thank you very much, Mr. Goldbeck, for a very provocative and interesting statement.

We will turn first to Senator Rockefeller for questions.

Senator ROCKEFELLER. Thank you, Mr. Chairman. "Dr. Ruane you state, the Federal Government should not interfere in the relationship between employer and employee." I assume that doesn't apply when your factory is burning down or when a crime is being committed, and you want the FBI or the local authorities to help?

Dr. RUANE. Of course not.

Senator ROCKEFELLER. I think your testimony is partly right, small businesses would have a tough time providing health insurance to all their employees. I wish that you had made a stronger case so that you could help people like myself, who are trying to find a solution to this problem.

The problem of the uninsured is a very difficult problem and I wish we could work together to figure out a way to make sure all Americans have health insurance. We need to work together. I'm dismayed that Dr. Ruane's testimony and Dr. Hoffman's testimony are so far apart. It frustrates me.

Dr. Hoffman in your testimony you state that all employers must be required to pay for a minimum package of health insurance benefits for all of their workers, and that there cannot be any exceptions for any businesses, or any particular types of employers—now, do you honestly mean that?

Dr. HOFFMAN. Yes.

Senator ROCKEFELLER. Have you ever been to West Virginia?

Dr. HOFFMAN. Yes.

Senator ROCKEFELLER. Do you honestly believe that without exception—all small businesses in West Virginia could conform with this.

Dr. HOFFMAN. I think if you just leave it at that point, obviously it is ridiculous on its face. However, what I am suggesting is that we go to extreme lengths to make it affordable, comfortable, with administrative ease, working through pooling arrangements, and through multiple employer approaches.

Obviously, each small employer, standing on its own in West Virginia or in Michigan, cannot do it on their own. It would be ridiculous to just go and say: You must do this just as General Motors or Chrysler has done. I agree with you 100 percent.

But there are a number of things that we can do to make it an approach that could be reasonable. And that is how I would answer your question.

Senator ROCKEFELLER. Yes, except that if you say no exceptions, how do you expect it to happen?

Dr. HOFFMAN. I think, again, we can't take it out of context. I would suppose that we could compare it to the national health insurance program that applies in Canada right now and where we have had 10 years of experience in bargaining and in working in small rural areas and where it applies.

So, it is not inconceivable. We can do it through an employer base. We can also expand that through providing tax incentives, through providing administrative organization, so that you can

pool all the farmers together in an area, all small businesses in an area.

Earlier, there was a description of how you would do it for all restaurant owners. I think there are severe problems, but I think if we just reject that it can happen, we have not done service to those employers and their employees. I agree it would be a tremendous, tremendous task; but we ought to get about it because those people don't have access to health care.

So, I share your concern. I just don't want to say it can't happen before we explore all the wisdom of Congress and the wisdom of the private sector in how to apply approaches that we know have occurred. We have multi employer pension plans. We have approaches in the employee benefits system that could approach this.

So, I don't reject it out of hand. I do recognize your concerns, and they are sincere concerns; and I share them.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Senator MITCHELL. Mr. Goldbeck, you are kind of lucky. Senator Rockefeller ran out of time.

Mr. GOLDBECK. Really. (Laughter)

Senator MITCHELL. Actually, it is Senator Heinz's turn.

Dr. RUANE. I would like an opportunity to respond to Senator Rockefeller, please.

Senator MITCHELL. I will give you that on my time, Dr. Ruane, because I have a question along the same lines; but it is Senator Heinz's turn now.

Senator HEINZ. I just wanted to add, Mr. Chairman, to what you just said a moment ago. Not only is Mr. Goldbeck lucky, but the other two gentlemen are very lucky because I happen to know that Senator Rockefeller is in an excellent mood today. (Laughter)

Senator HEINZ. Dr. Ruane, I assume that if we were smart enough to figure out a way for small employers to get their health insurance just as cheaply as the Washington Business Group on Health and its membership, which is large employers, that you would still be very strongly opposed to any mandate?

Dr. RUANE. We are opposed to the ideas of mandates from a generic point of view.

Senator HEINZ. Yes, I understand. But if that were the case, how would the small employers who basically are the people with the uninsured—the largest number of the uninsured, those that are working—how would you propose to get at this problem?

You have been sitting in the audience; you have heard some testimony today that says there are some fairly high prices that other people are paying. Is it right that other people should pay those prices?

Dr. RUANE. We would be in favor of tax deductions to offset some of those costs. I think that would be an alternative.

Senator HEINZ. Tax deductions to whom? To Mr. Goldbeck's people who are already getting tax deductions for their costs? But you know tax deductions aren't worth what they used to be worth.

That is nice, but they are still paying some of your bills. The taxpayer is paying what might be otherwise some of your bills. The hospitals are eating up some of their capital. Insurers are cross-subsidizing.

I am not saying you are responsible for that—you yourself—

Dr. RUANE. I hope not. (Laughter)

Senator HEINZ. We may end up there before the afternoon is out, but—(Laughter)

What is the solution to that problem? Is it to have the others paying more and more?

Dr. RUANE. No, it is not. I think the solution lies in the whole question of the actual cost to any employer, and that is why I emphasize in our statement that we hope the committee takes a hard look at the cost containment side of the equation as well.

Senator HEINZ. Let's assume we did a terrific job containing costs. We got the price down. Then what?

Dr. RUANE. Then, hopefully that would translate to a system where it would be more affordable to the average small business owner, that he could provide such insurance coverage to all of his employees.

Senator HEINZ. Dr. Hoffman, our first witness today, Dr. Blendon, who is from Harvard and has some familiarity with what Massachusetts has done, indicated that—as I understood him, and I wish there had been more time—in Massachusetts they had adopted a business ability to pay approach for the health insurance mandate.

Do you oppose or support the ability to pay approach to business?

Dr. HOFFMAN. I think that it is interesting. If you think about it in reverse terms, it is almost like means testing employers in terms of whether or not they can afford this mandated approach to health insurance. I don't have any problem with that.

Senator HEINZ. Mr. Goldbeck, what about you? What do you think of that?

Mr. GOLDBECK. Oh, I think it is a very reasonable experiment, and I think it is going to produce some very interesting evidence that the Congress can look at closely. I think the biggest question on all of the mandate issues from the standpoint of small business is: How fast do you require it to take place?

If you want to say that we are going to pass a mandate in 1988 and it is effective January 1, 1989, and you have to have a full health plan, you might have abject chaos on your hands.

Senator HEINZ. Maybe someone is suggesting that; I don't know that any of us are. Let me ask Dr. Ruane a question, and I am really getting back to you on the issue of cost.

Suppose we modified a mandate so that it reflected ability to pay? How much would you kick and scream about that?

Dr. RUANE. I think it is only reasonable that the small business community would alter its position if that were in fact the case, that it would be more amenable to any situation when coverage was affordable.

Senator HEINZ. At the risk of sounding like Senator Rockefeller, you said, though, that you are philosophically opposed to any mandate; and it sounded like you are opposed to it under any circumstances. Are you saying that that is really not accurate although, as I heard you, it seemed to me you said that?

Dr. RUANE. I qualified my statement with respect to the tax deduction aspect.

Senator HEINZ. We have talked about the tax deduction, and I think we all understand that there will be a tax deduction, but it

doesn't really answer the question we are driving at. What you are saying now is that—if I understand what you are saying; I don't want to put words into your mouth—first, if you could make sure that small business isn't paying a disproportionately high price per worker, that is one way of spelling relief.

Second, if small business isn't put out of business by having to pay more than it can afford to pay, that almost makes a mandate—almost makes a mandate—acceptable to you?

Dr. RUANE. I would agree. Yes.

Senator HEINZ. Thank you.

Senator MITCHELL. The Senate is now voting on an amendment. I have a number of questions which I will submit in writing.

[The questions appear in the appendix.]

Senator MITCHELL. Dr. Ruane, I would like to give you an opportunity to respond to Senator Rockefeller's remarks, if you care to do so in just a couple of minutes. As soon as the buzzer goes off again, Senator Heinz and I are going to have to leave to vote. So, we will give you the last word, and then we will conclude the hearing.

Dr. RUANE. I understand, Mr. Chairman. It is unfortunate my accuser cannot be here so I could confront him, but I would underscore that our position and I would call the attention of the committee to the primary recommendations of the U.S. Conference on Small Business, the White House Conference, in which the number two recommendation was against mandated health programs. I call attention to the variety and spread of organizations represented in our statement and the actual business owners who signed these petitions.

I think their point of view is in fact representative of small business across the country. I think small business people are fed up with having mandates thrust upon them by any level of government, and I think that sense of frustration needs greater recognition in the Congress. And that is what I was trying to represent here today.

Senator MITCHELL. Thank you very much. Gentlemen, thank you all very much. The hearing is concluded.

[Whereupon, at 4:17 p.m., the hearing was concluded.]

APPENDIX

ALPHABETICAL LIST AND MATERIAL SUBMITTED

DO ALL AMERICANS HAVE ACCESS TO NEEDED HEALTH CARE REGARDLESS OF THEIR ABILITY TO PAY?

Testimony by Robert J. Blendon, Sc.D.,
Harvard School of Public Health, before the
U.S. Senate Finance Committee, Washington, D.C.

July 25, 1988

Mr. Chairman, I would like to thank you for inviting me to testify today. My name is Robert Blendon, Sc.D. Currently, I am professor and chairman of the Department of Health Policy and Management of the Harvard School of Public Health. In addition, I serve as Deputy Director of Harvard University's Division of Health Policy Education and Research. Prior to this appointment I served as Senior Vice President of the Robert Wood Johnson Foundation in Princeton, New Jersey.

As members of this committee recognize, health care in 1988 is vastly different than it was a decade ago. An aging population, the looming physician surplus, the emergence of large multi-hospital corporations, the growth of Health Maintenance Organizations, the commercialization of medicine, new systems for paying our hospitals, technological advances, and a plethora of new outpatient treatment facilities are forcing changes in our health care system.

Senators invited to speak to civic, business, religious, and professional groups about health care quickly discover that many of these organizations have very differing views on these new health care directions. On one hand, some strongly believe that this is going to be "the Golden Age of American health care" -- more competition, lower hospital charges, more available doctors, the return of house calls, the introduction of "sound" business management practices, and new but adequate local arrangements for

providing medical care to the nation's poor and uninsured. Others, looking at the same "crystal ball," see a future of "cut-throat competition" leading to a decline in the quality of the nation's medical care, doctors and hospitals advertising and providing unnecessary and expensive medical procedures, and millions of those who are uninsured turned away from needed medical care by "business-like" health care institutions because of inability to pay.

Over the coming decade, The Congress will increasingly be confronted by these very polarized positions -- one set of constituents seeing these many changes leading to dramatic improvements in our health care system, while others see pending "national disaster." The reality is that this issue is not settled. Many of these rapidly unfolding changes are just beginning.

One of the most commonly asked questions about this changing environmeat is: Do all Americans have access to needed health care regardless of their ability to pay? Surveys show that Americans are almost unanimous (82%) in their support and concern for this principle.[1]

My testimony will attempt to answer this question briefly and simply. It relies on a number of data sources but most importantly on the 1986 UCLA-Robert Wood Johnson national survey of Access to Health Care (see appendix 1). My conclusions which I will describe in greater detail are as follows:

1. Most Americans who have health insurance report few difficulties in obtaining access to health care.

2. However, Americans without health insurance report major barriers to obtaining needed medical care.

3. America's "safety net" for those who are uninsured appears to be unravelling.

4. America's leadership groups are still struggling to find a consensus on how to resolve this problem.

1. Most Americans who have health insurance report few difficulties in obtaining access to health care. Nearly nine out of ten insured persons say that they did not have problems in obtaining the medical or surgical care they needed. A similar proportion report they had a regular source of medical care, be it a physician, hospital, HMO, etc., and they were satisfied with their last experience with it.[2,3,4]

2. However, Americans without health insurance report major barriers to obtaining needed medical care. Even though our country's hospitals now provide nearly ten billion

dollars a year of uncompensated care, national studies continue to show a wide disparity between the ability of the uninsured and the insured to obtain health services.[2,3,4] The UCLA - Robert Wood Johnson study describes this worrisome situation. As shown in Exhibits 1 and 2, people under the age of sixty-five without health insurance, although generally less healthy than their insured counterparts, saw physicians 27% less frequently and were hospitalized 19% less often. Similarly, this figure was 34% less for visits to physicians by uninsured children. In addition, the study found the general gap in receipt of physician care was widest for those who were in the most ill health (Exhibit 3). Those uninsured who described themselves as being in fair or poor health reported 40% fewer visits to a doctor than those with health insurance.

An estimated one million Americans reported that they actually tried to obtain needed medical care but were refused by doctors or hospitals for financial reasons. Similarly, an estimated 13.5 million Americans stated they were not able to obtain needed medical care because they did not have adequate economic resources. The majority of Americans experiencing these difficulties were uninsured or poor. In a finding equally as dramatic, the survey indicates that people without health insurance saw physicians 50% less often for symptoms of serious illness than those who were insured. The symptoms, judged by a panel of physicians to warrant seeing a doctor, included unexplained bleeding, periodic loss of consciousness or fainting, and chest pain when exercising.[2,3]

The large proportion of pregnant women who did not seek prenatal care in the first three months of their pregnancy is especially troubling. A recent Institute of Medicine study concluded that early prenatal care leads to improved maternal and infant outcomes.[5] However, although infant mortality in the United States has been reduced by half since 1970, the rates of infant death in this country still exceed those of many other comparable industrialized countries.[6] It is therefore of concern to find one in five uninsured pregnant women surveyed in 1986 did not seek medical care early in their pregnancies (Exhibit 4).[2,3]

Such barriers to care appear to be affecting the health of our young infants, both Black and White. As shown in Exhibit 5, our neighbor Canada, with similar medical knowledge, professional skills, and technologies, has been reducing its infant death rate at a faster rate than the U.S. In the last decade the Canadian rate fell 41% while the U.S. rate declined only 32%.[6,7]

These studies suggest that as a result of Medicare and Medicaid, to be poor in American is no longer a major deterrent to obtaining adequate health care.[8,9] But to be uninsured is! To be both uninsured and poor remains the most serious problem of all.

3. <u>America's "safety net" for those who are uninsured appears to be unravelling</u>. Over the years, the United States has gradually adopted a three-track system of health care financing. The first track has been private health insurance for employees and their families. The second is public insurance for the poor on welfare rolls, the disabled, and the retired. The third is a system of governmentally subsidized public hospitals and neighborhood health centers, coupled with a major commitment of more than six thousand philanthropically supported non-profit hospitals, that provide free or subsidized care to the poor who are not on welfare or to the uninsured. This three-track system appears to be breaking down. A number of forces are at work here:

- Private sector concerns with economic conditions and competitiveness have led since 1980 to a 25% increase in the proportion of Americans without health insurance (Exhibit 6).* Thus we see nearly two-thirds of the 37 million uninsured (62%) are in families with an adult currently holding a job, but without health insurance coverage.[10,11]

- Fiscal pressures on federal and state governments have resulted in a decline since 1975 in the proportion of the nation's poor and near-poor covered by Medicaid (Exhibit 7).[12,13] Similarly, while the number of uninsured has increased, the number of publicly supported neighborhood health centers has decreased.

- Real growth in philanthropic spending in health care has declined from 4.6% of national health expenditures in 1970 to 2.7% today. Real private giving is now a smaller source of revenues for the charity care offered by non-profit voluntary institutions.[14,15]

- The amount of "free care" provided by voluntary hospitals is not sufficient to meet the growing proportion of uninsured in the communities they serve. Communities that have no municipal hospital are encountering additional difficulties. Today one-third of the nation's hundred largest cities have no public free care institution and the poor must depend on non-profit hospitals for uncompensated care.[16]

- One of the indirect mechanisms by which the nation has financed care for the poor is rapidly changing. Historically, middle-class Americans have overpaid for their health care services, and these overpayments have subsidized care for

the poor. However, in the face of rising health care costs, many private business and union health insurance policies prohibit the shift of the costs of medical care for the poor to their members policies. This phenomena has been encouraged indirectly by the ERISA pension legislation.

These trends, when viewed together, suggest that the question of who will pay for the care of the uninsured is becoming a critical health care issue for the nation.

4. <u>America's leadership groups are still struggling to find a consensus on how to resolve this problem</u>. Having spoken to more than a 100 private and public sector groups about this issue, I recognize how difficult it remains to agree on a solution. Leaders in all walks of life -- Governors, state legislators, medical society presidents, insurance and health care executives, hospital administrators, foundation presidents, Mayors, etc. -- all agree that it is essential that someone pay for the health care of those who are uninsured. Their one caveat: it can't be them alone! Clearly it will require strong leadership from the Congress if a national consensus on resolving this dilemma is to be found.

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* Differing surveys continue to show some variation in the proportion of Americans who are uninsured. CPS data are utilized here because they provide a continuing time series.[4]

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APPENDIX 1

THE UCLA-ROBERT WOOD JOHNSON FOUNDATION ACCESS TO CARE STUDY

Conducted by
Howard Freeman, Ph.D.
Chairman of Sociology, UCLA

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Technical Appendix

Survey Design: The survey was designed to collect data from a randomly selected sample of people representative of adults and children in the United States. Data were gathered through telephone interviews of adults and through proxy interviews with a parent for children under 17. To measure the effects of omitting households without telephones, a separate probability sample of 300 such households was selected in three sites.

All computations used in the text and charts are based on weighted distributions to correct for oversampling of the chronically ill and some other groups and to allow estimates to be made for the total noninstitutionalized population of the United States.

10,130 people in the continental United States were interviewed from the spring through the fall of 1986, the same time of year during which interviews were conducted for the 1982 access survey. Interviews were conducted in English or Spanish.

When a household was reached through the random-digit dialing methods employed, a screening interview was conducted with an adult member of the household. Questions were asked about the conditions used to define illness and a household listing was completed. The computer then selected at random the household member(s) to be interviewed. If the randomly selected respondent was at home, the interview began immediately. Otherwise, the interviewer attempted to find a convenient time to call back.

At the end of the interview with the randomly selected adult, this individual was asked whether any family members had any chronic or serious illness or other health problem that prevented work, school, keeping house, or carrying out normal activities. If a sick adult or child was identified, that person or a proxy was subsequently contacted for an interview.

Data were collected from telephone center locations at the Urbana and Chicago offices of the Survey Research Laboratory, University of Illinois, and the Madison office of the Wisconsin Survey Research Laboratory, University of Wisconsin. In order to ensure that identical methods were used, all training was conducted by the same field coordinator who had also prepared the training material. The completion rate for individuals selected for interview was 76 percent.

Previous Surveys: The 1986 survey is the seventh in a series of national household surveys of access to health care. The first five were conducted by the Center for Health Administration Studies of the University of Chicago. The sixth was conducted by Louis Harris and Associates, Inc., with secondary analyses carried out by the Center for Health Administration Studies.

Some Definitions: Poor: The poor category is defined as below 150 percent of the poverty level established by federal guidelines. Determination of poverty level conforms to a Social Security Administration index and is based on family size and total family income, excluding the value of noncash benefits such as Medicaid.

Whites: Non-Hispanic Caucasians, Asians, Alaskan Eskimos, native Americans, and other except blacks.

Urban/Rural: The urban category corresponds to Standard Metropolitan Statistical Areas, or central city and suburban areas. Rural includes non-SMSA rural and farm areas.

Uninsured: The uninsured are those who did not have coverage under a health maintenance organization, Medicare, Medicaid, other government health insurance, self-paid health insurance, or employer-paid health insurance.

Chronically or Seriously Ill: People with asthma, emphysema, cancer, heart disease, stroke, high blood pressure, kidney or liver disease, diabetes, neurological disorders, mental retardation, pneumonia or influenza, serious injury, or other disabilities.

EXHIBITS 1-4

EXHIBIT 1

Mean Number of Physician Visits, Percent Hospitalized, And Perceived Health Status By Insurance Coverage For Persons Under 65, 1986

Insurance coverage	Physician Visits	Percent in fair/poor health
Uninsured	3.2	12%
Insured	4.4	9
Gap (percent)	-27%	
	Percent hospitalized	
Uninsured	4.6	12
Insured	5.7	9
Gap (percent)	-19%	

EXHIBIT 2

Mean Number of Physician Visits By Insurance Coverage For Children Under 17, 1986

Insurance coverage	Physician Visits	Percent in fair/poor health
Uninsured Children	2.5	6.4%
Insured Children	3.8	6
Gap (percent)	-34%	

EXHIBIT 3

Mean Numbers of Physician Visits For Those Under The Age of 65 in Fair or Poor Health, 1986.

Insurance Coverage	Physician Visits
Uninsured	6
Insured	10
Gap (percent)	-40%

EXHIBIT 4

Indicators Of Potential Underuse Of Medical Care, 1986

Problem	U.S.	Uninsured
Percent with chronic illness without physician visit in a year	17%	20%
Among persons with one or more physician visits in year, percent with serious symptoms who did not see or contact a physician.	41	67
Percent pregnant women without first trimester prenatal care	15	20
Percent of Americans not receiving care for economic reasons	6	20

Exhibit 5

Infant Mortality, United States and Canada 1960 - 1986

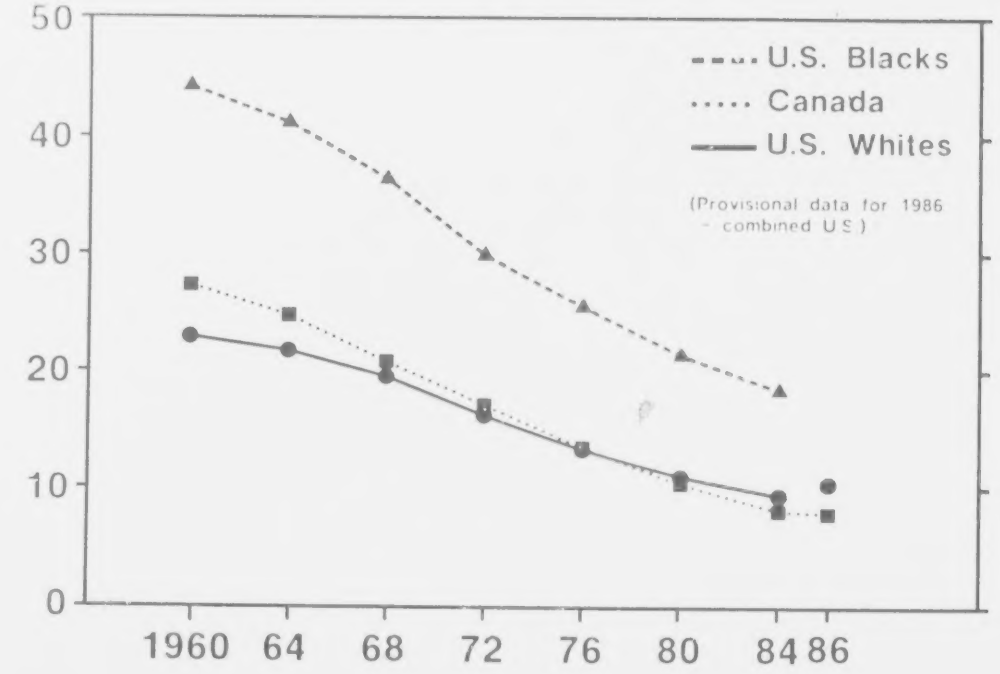
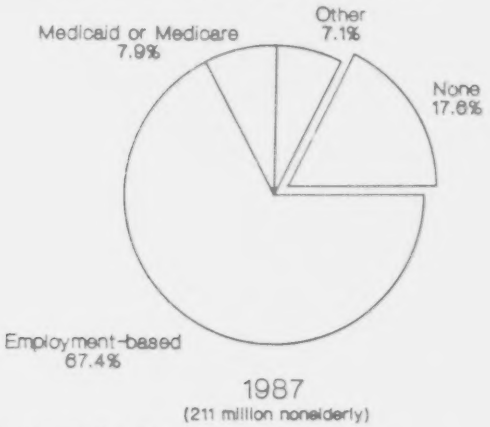
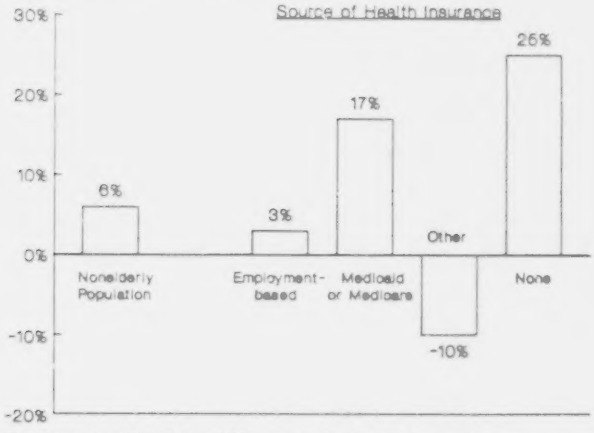


EXHIBIT 6

Sources of Health Insurance for the Nonelderly Population, 1987



Percentage Change in the Nonelderly Population and Their Sources of Health Insurance, 1980-1987

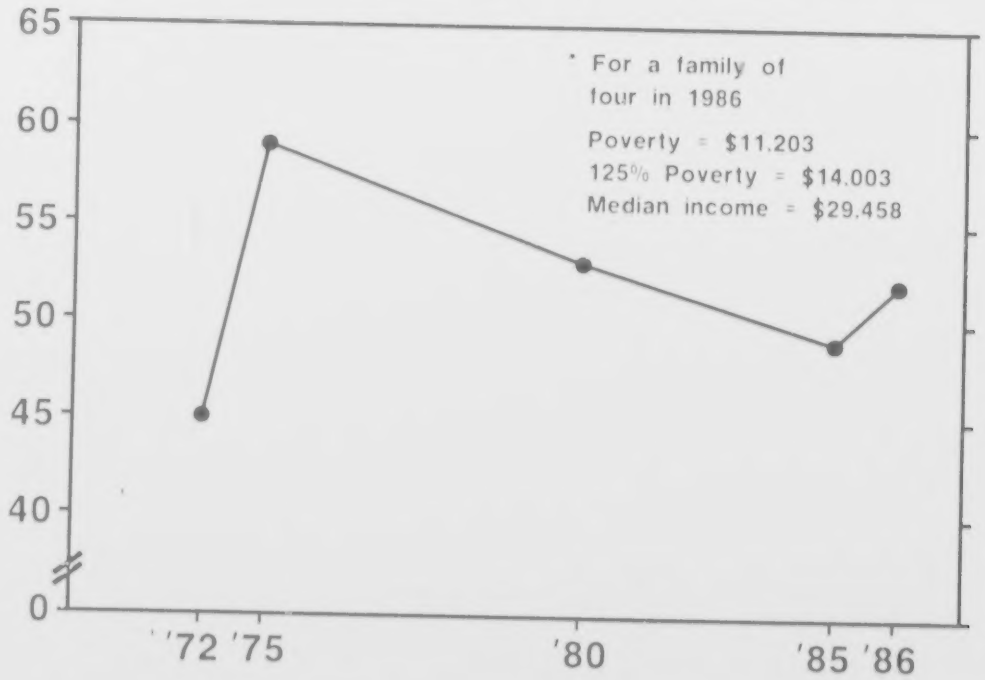


SOURCE: Congressional Budget Office tabulations of the March 1980 and March 1987 Current Population Surveys.

NOTE: The surveys ask respondents about insurance coverage during the last year. Because of recall error, however, the responses are more likely to reflect current or recent coverage. Therefore, for example, these figures assume that the March 1987 survey reflects insurance coverage in the early months of 1987.

Exhibit 7

Medicaid Recipients as a Percentage of Persons Below 125 Percent of Poverty* 1972 - 1986



STATEMENT BY

SENATOR JOHN H. CHAFEE

AT

FINANCE SUBCOMMITTEE ON HEALTH

HEARING ON

HEALTH CARE FOR THE UNINSURED

JULY 25, 1988

Mr. Chairman, I commend you for holding this hearing. I believe that one of the most serious and troubling problems we face in this country today is the number of people, especially children, who are without any health care coverage.

It is for this reason that earlier this year I introduced MedAmerica, S.1139, which would substantially expand the Medicaid program.

MedAmerica would build on the existing Medicaid program in four ways:

First, it would sever the tie between Medicaid and cash benefit programs -- such as AFDC and SSI. With small exceptions, only those who are eligible to receive welfare can get Medicaid benefits. As a result, on average only those who are under 48% of the poverty level are currently receiving medical assistance through Medicaid. Under my proposal, states would have the option of providing Medicaid benefits to anyone whose income is below the federal poverty level, which is $6,000 for an individual and $10,000 for a family of four, regardless of whether or not they qualify for welfare.

Second, it would allow individuals -- the so-called "working poor" -- whose incomes are between 100 and 200 percent of the federal poverty level to purchase health insurance through Medicaid for an income-adjusted premium, not to exceed 3% of the individual or family's adjusted gross income. This provision will allow a family of four with an income of below $20,000 to purchase Medicaid insurance.

THIRD, IT WOULD ALLOW PERSONS WITH FAMILY INCOMES AND RESOURCES IN EXCESS OF 200% OF THE FEDERAL POVERTY LEVEL TO PURCHASE MEDICAID FOR A NON-INCOME ADJUSTED PREMIUM IF THEY HAVE BEEN EXCLUDED FROM PRIVATE HEALTH INSURANCE COVERAGE BECAUSE OF A MEDICAL IMPAIRMENT OR DISABILITY OR IF THEY HAVE EXHAUSTED ONE OR MORE BENEFITS UNDER THEIR PRIVATE INSURANCE PLANS.

FINALLY, THE BILL WOULD ALLOW BUSINESSES OF LESS THAN 25 PEOPLE TO PURCHASE THE MEDAMERICA PLAN FOR THEIR EMPLOYEES IF THEY CAN NOT FIND COMPREHENSIVE HEALTH INSURANCE AT A REASONABLE COST IN THE PRIVATE SECTOR.

IF ALL OF THESE PROVISIONS WERE ADOPTED, MEDAMERICA WOULD COVER ABOUT TWO-THIRDS OF THE 37 MILLION WHO CURRENTLY HAVE NO HEALTH INSURANCE COVERAGE.

I INTRODUCED THIS PROPOSAL BECAUSE I FELT THAT DISCUSSIONS ON HOW TO DEAL WITH THE ISSUE OF THE UNINSURED AND THE UNDERINSURED WERE OVERLOOKING AN IMPORTANT OPTION: THE USE OF AN EXISTING PUBLIC SYSTEM. EVEN IF CONGRESS WERE TO MANDATE THAT BUSINESS PROVIDE HEALTH INSURANCE TO ALL EMPLOYEES, WE WOULD STILL BE MISSING A LARGE PORTION OF THOSE CURRENTLY WITHOUT COVERAGE.

SOME PEOPLE HAVE BEEN CRITICAL OF THE IDEA OF EXPANDING A FEDERAL PROGRAM IN A TIME OF HIGH DEFICITS, I DON'T AGREE WITH THEM. I DO NOT BELIEVE WE CAN AFFORD TO IGNORE THE HEALTH CARE NEEDS OF OUR CITIZENS ANY LONGER.

WHY IS HEALTH CARE SUCH A CRITICAL INVESTMENT? BECAUSE IT IS WRONG FOR ANYONE TO BECOME ILL SIMPLY BECAUSE THEY DO NOT HAVE ACCESS TO HEALTH CARE. BECAUSE IT IS WRONG THAT EMERGENCY ROOMS ARE IN THE POSITION OF PROVIDING PRIMARY CARE. BECAUSE IT IS WRONG AND INEFFICIENT FOR OUR HEALTH CARE SYSTEM TO PAYING FOR ILLNESSES THAT COULD HAVE BEEN PREVENTED.

IF THESE REASONS ARE NOT ENOUGH, WE CAN LOOK AT IT FROM AN INVESTMENT PERSPECTIVE.

IF PRESENT TRENDS CONTINUE, AMERICAN BUSINESS WILL CONFRONT A SERIOUS LABOR SHORTAGE IN ONLY A FEW YEARS. BY 1990 THE IMPACT OF NEW TECHNOLOGIES IS EXPECTED TO DRIVE TOTAL PRIVATE SECTOR DEMAND

FOR EMPLOYMENT TO 156.6 MILLION JOBS -- NEARLY TWICE THAT IN 1978. SMALL BUSINESSES ARE ALREADY HAVING DIFFICULTY FILLING AVAILABLE JOBS. EVEN IF THESE ESTIMATES ARE ONLY CLOSE TO THE MARK, THERE WILL BE A SHORTAGE OF OVER 23 MILLION AMERICANS ABLE TO WORK.

AS THE PERCENTAGE OF CHILDREN IN OUR SOCIETY CONTINUES TO DECREASE, OUR LABOR SHORTAGE WILL BECOME EVEN MORE ACUTE. NOT ONLY WILL THERE BE A LACK OF QUALIFIED JOB SEEKERS, THERE WILL ALSO BE A SIMPLE LACK OF PEOPLE TO BECOME QUALIFIED.

WE CANNOT AFFORD TO SEE ANY POTENTIAL WORKER DIE OR BECOME AFFLICTED WITH A SERIOUS ILLNESS WHICH COULD HAVE BEEN PREVENTED. THIS APPLIES TO NEWBORNS, INFANTS, CHILDREN, AND TEENAGERS AS WELL AS THOSE CURRENTLY IN THE WORKFORCE. IN ORDER TO PREVENT SUCH ILLNESS, THESE INDIVIDUALS MUST HAVE ACCESS TO GOOD AND AFFORDABLE HEALTH CARE.

ONE OF THE MOST OBVIOUS EXAMPLES OF THIS IS THE DEBATE IN BOTH THE PRIVATE AND PUBLIC SECTOR OVER PRENATAL CARE. PRENATAL CARE IS INCREDIBLY COST EFFECTIVE. YET, THERE IS A GREAT DEAL OF RELUCTANCE TO COVER IT. HOW ABSURD. IT COSTS ABOUT $700 TO GIVE A MOTHER A PROPER PRENATAL CARE PACKAGE. ON THE OTHER HAND CARE FOR A LOW BIRTH WEIGHT BABY COSTS AT LEAST $7,000. THE CARE OF A BABY BORN WITH A DEVELOPMENTAL DISABILITY CAN EXCEED ONE MILLION DOLLARS OVER THEIR LIFE TIME.

WHEN YOU THINK OF THIS IN TERMS OF INVESTING IN OUR FUTURE THE RELUCTANCE TO PROVIDE APPROPRIATE HEALTH CARE IS ASTOUNDINGLY SHORT SIGHTED. QUITE SIMPLY, GIVEN OUR ECONOMIC SITUATION AND OUR CONCERN FOR THE FUTURE THIS IS AN INVESTMENT WE CAN NOT AFFORD TO AVOID ANY LONGER.

WHAT ARE OUR OPTIONS FOR FINANCING?

I BELIEVE THAT A COMBINATION OF PRIVATE AND PUBLIC SECTOR INVOLVEMENT AND FINANCING IS NECESSARY. THE REAL ACCESS PROBLEM IS FOR THOSE WHO ARE IN LOWER WAGE JOBS AND WITH SMALLER COMPANIES

THAT ARE OPERATING WITH LIMITED CASH FLOW. SMALL BUSINESSES HAVE A PARTICULARLY DIFFICULT TIME FINDING REASONABLE RATES FOR HEALTH INSURANCE AND AS A RESULT, THEY RARELY ARE ABLE TO OFFER THE BENEFIT TO THEIR EMPLOYEES, LET ALONE THE EMPLOYEES' FAMILIES.

THE MEDAMERICA APPROACH DOES NOT ADDRESS MANY CRITICAL ISSUES. FINANCING IS ONE OF THEM. OTHERS INCLUDE UTILIZATION REVIEW, QUALITY CONTROL, PROVIDER PARTICIPATION AND REIMBURSEMENT. THIS WAS INTENTIONAL. I DID NOT WANT TO SEE THE IDEA BECOME SO CLOUDED WITH OTHER ISSUES THAT THE CONCEPT OF A MEDICAID BUY-IN WAS OVERLOOKED. AS I HAVE DISCUSSED THE BILL WITH INDIVIDUALS AND ORGANIZATIONS, I HAVE RECEIVED MANY INTERESTING IDEAS ON HOW TO APPROACH THE SHORT COMINGS OF THE BILL AND I INTEND TO REFINE THE LEGISLATION AS WE MOVE FORWARD THIS YEAR. I AM VERY INTERESTED IN THE THOUGHTS OF THE WITNESSES TODAY.

ONCE AGAIN MR. CHAIRMAN, I COMMEND YOU FOR HOLDING HEARINGS ON THIS CRITICAL ISSUE.

TESTIMONY OF KAREN DAVIS

CLOSING THE GAPS IN HEALTH INSURANCE COVERAGE

Thank you, Mr. Chairman, for this opportunity to testify on the absence of health insurance coverage among certain segments of the population. As the cost of health care has risen sharply over the last decade, even families with moderate incomes can face devastating medical care bills unless they are protected by health insurance. Fortunately, about 85 percent of all workers and their families receive such health insurance from their employers. For a significant minority, however, gaps in employer-provided health insurance pose significant barriers to needed medical care and undermine the health and economic security of families struggling to earn a livelihood. Particularly alarming is the fact that access to health care in this nation is becoming worse not better and the ranks of the uninsured are swelling.

Today, I would like to share with the Committee the latest data on trends in gaps in health insurance coverage, what we know about the consequences of these gaps in coverage, and suggest ways in which gaps in health insurance coverage could be closed.

Employment and the Uninsured

With passage of the Medicare program in 1965, virtually all elderly Americans were assured of at least some health insurance coverage. Passage of the Medicare Catastrophic Coverage Act this year is important and should particularly benefit those elderly Americans with modest incomes who can not afford to purchase supplementary coverage.

However, many of the nonelderly face a far more serious problem -- the absence of even minimally essential basic

health insurance coverage. In 1986 37 million Americans, or about 17.6 percent of the nonelderly population, did not have any health insurance coverage.

Particularly disturbing is the fact that the ranks of the uninsured are growing. In 1980, 30 million Americans, or 15 percent of the nonelderly population, did not have health insurance coverage. Today there are 7 million more Americans without health insurance coverage than was the case six years ago.

People under age 65 obtain health insurance coverage in three ways: they receive group health insurance provided by their employer, they purchase health insurance individually from private health insurance companies, or they qualify for coverage under the Medicaid program.

Coverage under an employer health plan is the most common way in which the nonelderly obtain health insurance coverage. About 132 million of the 209 million nonelderly population, or about two-thirds, have employer-provided health insurance coverage. About 24 million are covered by Medicaid or other public programs. About 16 million purchase private health insurance coverage individually, leaving 37 million uninsured.

The common impression is that the uninsured are outside the work force -- mostly young adults who have not yet found jobs. This is not the case. Surprisingly, over half of the uninsured, 19.6 million people, are in families where at least one member has a full-time job working 35 or more hours per week. Seventy percent of all the uninsured are in families where at least one member works at least 10 or more hours per week. The remaining 30 percent are unemployed or out of the labor force.

About one-third of the uninsured are children under age 18. Sixteen percent of the uninsured are between the ages of

45 and 65. The remaining half of the uninsured are between the ages of 17 and 45.

Another common impression is that Medicaid covers all of the poor. In fact Medicaid covers less than 40 percent of the poor. Absence of Medicaid coverage among the poor occurs because states set income eligibility levels well below the federal poverty level and because categorical restrictions limit coverage largely to one-parent families -- excluding two parent poor families, childless couples, and single individuals.

Nearly all of the uninsured have modest incomes. About one-third have incomes below the poverty level. Only 20 percent have incomes greater than three times the poverty level. Individual purchase of private health insurance is not economically feasible for most of the uninsured. Individual plans typically have inadequate benefits and charge premiums well in excess of actual benefit outlays.

Gaps in employer-provided health insurance coverage occur because such coverage is optional for employers. About half of all employed uninsured persons work in firms with fewer than 25 employees. Employer-provided health insurance coverage is particularly low in certain industries--including agriculture, construction, retail trade, and services. Coverage of workers is lower in the South and West than in the North and Central regions of the country.

To a considerable extent health insurance coverage in this country is a matter of luck. Those fortunate enough to be employed by large, unionized, manufacturing firms are also likely to be fortunate enough to have good health insurance coverage. Those who have modest incomes, live in the South and West or in rural areas, and those who are black or minority group members are more likely to bear the personal

and economic effects of lack of insurance and the consequent financial barriers to health care.

While the patchwork private-public system of financing health care in the U.S. explains why a significant part of population does not have health insurance coverage, it is less clear why the number of uninsured is rising. When the first evidence on growth in the uninsured population in the early 1980s became available, it was assumed that this was in large part a reflection of the deep recession of 1982-1983 and rising unemployment. Yet, with improving economic conditions in 1985 and 1986, the numbers of uninsured have not declined, but have continued to rise slightly from 35 million in 1984 to 37 million in 1986.

Several reasons have been advanced to explain the growth in uninsured:

- The growth of jobs in the service sector which tend not to have health insurance coverage.
- The growth of jobs in smaller firms.
- The decline in Medicaid eligibility.
- The increasing tendency for employers to require employee contributions to health insurance premiums, including paying the full cost of dependent coverage.
- The growth in one-parent families, which are less likely to have health insurance coverage than two-worker families.

While considerable further analysis and research will be required to sort out the independent contribution of these and other factors, it is clear that gaps in employer-provided health insurance are responsible for a large portion of the uninsured population.

<u>The Uninsured and Access to Health Care</u>

A new report on access to health care in 1986 recently

released by the Robert Wood Johnson Foundation contains evidence on the deterioration in access to health care in the 1980s. Thirteen and one-half million people reported not receiving medical care for financial reasons. An estimated one million individuals actually tried to obtain needed care but were turned away. Several indicators suggest that progress in improving access to health care for the poor and minorities has been reversed between 1982 and 1986.

The Robert Wood Johnson Foundation access survey found particular problems for the uninsured. The uninsured are one-third more likely to be in fair or poor health than the nonelderly insured. Yet despite their poorer health status, the uninsured receive 27 percent fewer physician services and are hospitalized 19 percent less frequently than the insured. One-fifth of the uninsured with chronic illness did not see a physician during the year. Fully two-thirds of the uninsured with serious symptoms (e.g. bleeding, loss of consciousness, chest pain, shortness of breath, weight loss unrelated to diet) did not see or contact a physician. One-fifth of uninsured pregnant women did not receive care in the first trimester of pregnancy. Twenty-two percent of the uninsured with hypertension did not receive a blood pressure check in the year.

Clearly, absence of health insurance coverage is not only a serious financial problem it is a health problem as well. Millions of Americans are at risk of death and disability because of an inability to pay for needed health care.

Alternative Approaches to Closing the Gaps in Health Insurance Coverage

It is urgent that action be taken to provide at least some minimum health insurance coverage for all Americans. In

evaluating the economic impact of any one approach to dealing with this problem, it is important to consider the alternatives. The major approaches which could be followed to close the gaps in health insurance coverage include:

- Expanding public programs such as Medicaid or Medicare to cover the uninsured or establishing a new public program,
- Subsidizing the purchase of individual private health insurance through federal or state government funds,
- Taxing hospitals or private health insurance plans to create a pool for paying for care for the uninsured, or
- Requiring employers to provide health insurance coverage for employees and dependents.

The first of these alternatives would require substantial new taxes from corporations or individuals. Given current governmental budgetary problems, public funds might be better targeted on those low-income uninsured falling outside the workforce. In addition since some of the working poor and near-poor have private health insurance coverage through employers, public coverage would displace current private coverage and add considerably to public outlays.

The second approach would also require additional taxes to pay for subsidies of an inherently inefficient type of health insurance coverage. Individual health insurance plans run administrative costs 30 to 50 percent of benefits, compared to 3 to 5 percent for Medicare and Medicaid. Public monies would go further by directly covering the uninsured under Medicaid or Medicare than by indirectly subsidizing coverage under individual private health insurance plans.

The third approach of taxing hospitals or private health insurance plans would shift the financial burden of covering the uninsured onto the insured. Those employers providing coverage for their workers would be doubly burdened--picking up the costs of their own workers plus the cost of workers in firms not providing such coverage. In a given industry, firms providing health insurance coverage for workers would be at a serious competitive disadvantage to those firms not providing such coverage.

In the light of these alternatives, requiring minimum employee health insurance coverage has much to commend it. It would minimize new taxes required to fill the gaps in health insurance coverage. It would build on the current system of employer-provided private group health insurance. It would spread the cost of expanded coverage more equitably among firms, rather than concentrating the burden on those firms voluntarily electing to provide coverage to their workers. It would permit limited public funds to be targeted onto low-income individuals not covered by employer plans.

Policy Proposal to Improve Health Insurance Coverage

I would like to suggest for consideration a partnership between the public and private sectors to begin to close the gap in coverage. This proposal has two major components:

- Mandating a minimum health insurance plan to be provided by employers to full-time workers and their dependents; and
- Residual coverage under Medicaid available to everyone falling outside employer plans on a sliding-scale premium contribution basis.

Employer Mandate

Provisions of a minimal health plan should be kept modest to keep premiums affordable. Improvements can be made

over time as economic conditions permit. Such a minimal plan might include:

- Coverage of workers working 25 hours or more per week and their dependents.
- Employer contribution of at least 75 percent of premiums.
- Extension of coverage for 90 days following termination of employment with employers continuing to pay their share of the premium.
- Minimum benefit package including inpatient hospital services, physician and other ambulatory services, preventive care including complete prenatal, delivery, and total infant care without cost-sharing, home health care, and limited mental health care.
- Maximum cost-sharing per family of $2,500 or $1,250 for an individual. Maximum deductibles of $500 and coinsurance of 25 percent.
- Choice of federally qualified HMOs and PPOs where available.
- Option for small firms or low wage firms to purchase Medicaid coverage for workers and dependents with a 50 percent employer and 50 percent employee contribution (given the more comprehensive Medicaid benefit package).

The specifics of such a package could be altered balancing the desire to have minimally adequate coverage with the desire to keep the premium low.

The primary criticism raised against such a proposal is that it would be an economic burden on low-wage firms and might result in loss of jobs for low-wage workers. There is some evidence that suggests a 10 percent increase in labor

costs might result in a one percent decline in employment. Applying this to the low-wage uninsured suggests a potential employment loss of 60,000 to 100,000 jobs. However, this loss of jobs would be more than offset by additional jobs of 100,000 or more in the health sector to provide new services.

There is reason to believe that even these modest adverse employment effects are overstated. First, the plan outlined does not constitute an excessively burdensome plan. It is estimated that a modest package could be provided for $0.50 to $0.60 per hour. Second, the labor market for entry-level workers is tightening with the drop in fertility in the mid-1960s leading to a smaller size cohort entering the labor force. Loss of jobs in such an environment is less likely. Third, the minimum wage has not been increased since 1981, so that the cost of entry-level workers has declined in real terms over the last six years. Fourth, the types of jobs that are potentially affected are largely in the service sector or retail trade which are not as sensitive to international competition.

Another concern is that small firms would not be able to purchase health insurance economically. The option of purchasing Medicaid gives small employers an alternative if private health insurance premiums are excessive. In addition consideration could be given to providing reinsurance for small firms, incentives to create multi-employer groups in the same industry for purposes of health insurance coverage, or selection of an insurer in a given geographic area to provide coverage to all small businesses on the basis of competitive bids. The Massachusetts approach of requiring employers to pay a tax set at some fixed percentage of payroll up to some earnings level unless the employer provides an equivalent contribution to health insurance for workers and dependents is another alternative.

Medicaid Coverage

Requiring employers to provide coverage for their workers and dependents would add 22 million more people to health insurance coverage, and drop the number of uninsured from 37 million to about 15 million. Most of the remaining uninsured are poor or near-poor and could be extended coverage under Medicaid.

Under this proposal, the Medicaid program would be expanded to provide acute health care benefits to the entire population falling outside employer mandated coverage and Medicare coverage. It would provide complete coverage to all poor and premium-financed coverage to others. Medicaid would be a secondary payer for individuals covered under employer plans or Medicare.

The provisions of this component include:

- Automatic coverage of all individuals under the poverty level.
- Optional purchase of Medicaid to all nonpoor not covered under an employer plan on a sliding scale premium basis.
- The Medicaid program would cover the current mandatory benefits plus prescription drugs, without arbitrary limits on amount, duration, or scope of benefits. For individuals purchasing coverage with a sliding-scale premium, modest cost-sharing provisions could be included.

Of the 15 million individuals left uninsured by the employer mandated coverage, 7 million individuals with incomes below the federal poverty level would be newly covered by Medicaid. Another 3 million individuals with incomes between the poverty level and twice the poverty level would be eligible to purchase Medicaid coverage on a

subsidized basis. About 5 million remaining uninsured with incomes above twice the poverty level could purchase Medicaid by paying the full actuarially fair premium.

Summary

The private-public partnership set forth here is an economically and administratively feasible approach to remedying the gaps in health insurance coverage that threaten the health and well-being of a significant portion of our nation's population. While the specific details could be modified, or even more modest steps taken incrementally to close these gaps in coverage, the plan proposed here should be carefully considered and debated. I congratulate the Committee for undertaking serious examination of ways in which such gaps in coverage can be eliminated. Thank you.

STATEMENT OF
SENATOR DAVE DURENBERGER
HEARING ON THE UNINSURED
JULY 25, 1988

Mr. Chairman, thank you for holding this hearing. We must turn our attention to the problems of the uninsured and the failures in our health financing system. Changes in the economy of the United States, including a shift to more of a service- based economy, and changes in household and family composition have increased the number of people without basic employee benefits. Our national income and benefits policies must take into account these shifts and compensate for some of the negative effects that we are seeing. In addition, clinical and basic research have given us a growing number of miraculous operations and procedures which either save lives or vastly improve the quality of life. But they can also quickly make even a good health insurance policy seem inadequate. We particularly see such medical miracles at places like Minneapolis' Children's Medical Center but we also see young parents with severely ill newborns without health insurance. Hospitals have billions of dollars worth of "uncompensated care," each year primarily because many of their costliest patients have no insurance.

It is absurd that the United States has such a large and still growing number of people without health insurance. The numbers are frequently quoted so I won't repeat them. But, although the exact number can be disputed, there is no question that we should have no one who is without basic health care coverage; certainly, we should not have more than 31 million uninsured, two-thirds of which are employed parents and their dependents.

I have long believed that every American should have a plastic card that gives every American access to a health plan of his or her choice. Each person could receive the plastic card through different funding or benefits sources, such as through employers for the majority of Americans or Medicare for the 32 million elderly and disabled. Only when everyone has coverage can we ensure that the appropriate mix of benefits, incentives, individual and collective resposnibility are part of everyone's "health plan." We can also begin to ensure that preventive health care is available to all americans.

My proposals, which include continuing the important Medicaid expansions that we have authorized in the Finance Committee over the past 3 years, all maintain pluralism, individual choice and coverage for all individuals. I believe that most Americans will choose to join a great variety of health plans, organized around group practices. We need to be sure that all of them have access to reasonable affordable health plans. The employed should get coverage through their employers and we need to assist small businesses in obtaining affordable insurance. The medically uninsurable should be able to obtain their insurance through risk pools, such as the excellent one that has worked in minnesota for more than 10 years.

There will be special populations who need to be protected in a different way. While designing financing methods for most americans, we must recognize the smaller but more complicated group of the nonworking, uninsured (about 25%) who include the homeless, the deinstitutionalized mentally ill, the recently incarcerated, and other marginal individuals for whom the traditional health system is inadequate.

Mr. Chairman, I am pleased that you are holding this hearing at this time so that we can begin the important work of finding effective solutions for these problems. We must stop the erosion in health benefits and coverage in this country and make certain that every American has a plastic card to access the health plan of his or her choice.

America's Uninsured

Invited Testimony Provided To

U.S. Senate Finance Committee

by

Willis B. Goldbeck
President

Washington Business Group on Health

July 25, 1988

Twenty five years ago Congress was in the midst of fixing the U.S. healthcare system. Rather than formally adopt a national health plan, it was decided to build upon the use of employment as the primary distributional vehicle for our residents to obtain health insurance. Two groups, the poor and elderly, who were generally not connected to the workforce and thus were not considered a viable economic market by the insurance industry finally obtained a measure of protection with the passage of Medicaid and Medicare.

Fifteen years ago, those who had long advocated national health insurance rekindled the flame and came within a single Ways and Means Committee vote of passing the Kennedy - Mills bill. An alternative, Senator Long's catastrophic proposal, received nearly enough support to pass and the hot issue of 1975-76, health insurance for the unemployed, became a surrogate for National Health Insurance (NHI) and it, too, came close to passage.

While these three "near misses" could point to many different reasons for their failure, they also shared one major barrier: private employment based insurance was expanding in scope and comprehensiveness on a voluntary basis every year. Medicare and Medicaid, still very young operationally, were both expanding and being administratively improved. In effect, we did not fully embrace NHI for the best and most simple of reasons: our existing model was working. Indeed, major employers, politically active in health policy for the first time through the (1974) creation of the Washington Business Group on Health and the Business Roundtable Task Force on Health, could with a clear social

conscience, say "leave us alone because we are doing exactly as you (Congress) wish (expanding coverage) without any governmental intervention."

In 1988, unfortunately, the same statement cannot be made and Congress is hearing the footsteps of a growing army of uninsured persons marching to the polls.

The bad news is, all three parts of the U.S. health care system are in significant decline. Medicare does not provide the correct mix of chronic and preventive services to balance its traditional overemphasis on acute care; Medicaid covers less than 50% of the poor; and some two-thirds of the uninsured are workers or their dependents who do not receive health benefits. Further, economic, demographic, labor, and social trends all suggest that the resolution can no longer be found in simple tinkering with the current model.

The good news is, the past six to ten years have provided a base of experience and experimentation rich in evidence not only about what is wrong but also about an array of responsible action strategies. The increased attention to and investment in cost management; prospective payment; preventive services; mental health; rehabilitation and disability management; publically accessible data systems; regional, state and local coalitions; the prevention of infant mortality; long term care; and the re-allocations of responsibility among public (federal, state and local) and private purchasers are all essential building blocks for any new systems which stand a chance of removing the uninsured from the list of America's social problems.

The Parameters of Progress

The uninsured do not represent an isolated problem which can find resolution absent an honest look at several related problems and changes in our socio-demographic landscape.

1. New job formation is concentrated on low wage positions in small firms that provide little or no benefits. Political pressure at the state and federal level to get employers to do more; a common activity of the past decade, has simply resulted in new mandates for the employers who already provide benefits and new incentives for others to continue to refuse.

2. For the past several years, every high school graduating class contains more illiterate youth and is reduced in size by those who have dropped out, left to have babies, fallen into lives of drugs and crime or joined the growing rank of teen suicides. In addition to all the other problems this

awful trend represents, it is a guarantee of increased ranks of the uninsured. Ninth grade drop outs will not be employed by companies with good benefits, will not pay taxes before collecting Medicare, will not be prudent health care consumers or adopt healthy life styles. They will; however, drop in -- into the emergency room, the drug clinic, the prison hospital and into the health care costs of all of us as we are methodically "surcharged" by providers to make up the losses of otherwise uncompensated care.

3. Medicare will find its inexorable race to bankruptcy (yes, again) made all the faster by the virtual elimination of retiree medical benefits in the private sector. The courts may have protected current retirees from benefit removal but of far more long term significance is the fact that future retirees, including the huge baby boom generation, are either being offered no benefits at all or are having defined benefits restructured to guarantee far more utilization of Medicare.

4. AIDS exposes every weakness in a health system which is still largely based on the sale of a free market product...insurance.

5. The homeless are an element of the uninsured issue that represents an increasingly visible statement about the economic bifurcation of the U.S. population along economic lines.

All of these factors, and there are more, point to the harsh reality that solving the problems of the uninsured will be neither fast nor inexpensive. To think that the nearly 37,000,000 uninsured, and the millions more who have only the most marginal coverage, will gain protection via "budget neutrality" is simply not realistic.

Cost Effectiveness of Protection

Putting aside the moral imperative of access to health care as a basic right along with food and shelter, it can clearly be demonstrated that it is less expensive for society to have people covered by well designed and managed health insurance plans than to have them rely on the emergency room route to access. So saying, does not mean that the best solution is the simple provision of a health insurance plan or mandate for anyone now uncovered. All that would do is give millions of people the financial capability to feed the economic fires of inappropriate, unnecessary, and generally unaccountable medical care consumption.

Employers Perspective

Just as there is not one homogeneous group of the uninsured, there is also wide diversity of opinion and participation by employers concerning this issue. All WBGH member companies

provide extensive benefits and, in most cases, have facilities in many states. They are also the employers who have provided the leadership in constructive cost management, generation of new competitive market forces through the use of alternative delivery systems and the development of health care data systems designed for utilization review, employee education and provided accountability; new benefits in prevention, hospice, case management, home health and employee assistance programs. We even see benefit coverage being expanded such as the recent decision of Sears to cover thousands of part-time workers.

These are good trends but they have to be viewed within the context of the tax increases imposed by the rapidly escalating shift of Medicare responsibilities to employers; the very costly expansion of social responsibility embodied in COBRA; the totally unnecessary administrative burden of Section 89 non-discrimination tests which are really a thinly veiled health policy disguise for a revenue raising tactic; the many legislative proposals to increase payroll taxes to finance new health care programs for people who are not employees; the more than 700 state mandated benefits which have become the health care professions' most successful mechanism for avoiding the costs of marketing or the necessity of proving any value or even necessity for their product or service; and, finally, the growing pressure for a federally mandated benefit to be required of all employers thus officially moving health insurance from an employee benefit to a legislatively required cost of doing business.

Section 89 is a perfect example of why the best employers are the most frustrated. The rules under Section 89 will unequivocally exacerbate the problem of the uninsured. Any employer currently not offering health coverage or family coverage would be making a very poor management decision to do so in light of these rules. In addition, the law's complexity and lack of timely regulatory guidance will force plan sponsors to reduce health benefit options in order to comply with this law.

With this litany of change as background, let me provide the perspective of our large employer members on several aspects of the uninsured issue. I will be brief and will be happy to provide the Committee with more details at any time.

A. Risk pools

As the recent GAO study made clear, these do not offer a

viable solution. A few people are helped but the price is much too high, the acceptance too low, the reliance upon rejection by insurance carriers represents little more than a tax subsidy for that industry, and the vast majority of the current uninsured population would not have even a fraction of the resources needed to qualify. The only way risk pools can be effective is if they are large enough, with participation required of diverse populations, and that they represent a true return to the basic insurance principle of spreading the risk.

B. Medicaid

We endorse two generic changes to Medicaid: first there needs to be a national eligibility standard set at the federal poverty level. Poverty is not an issue of states' rights, thus national commitments to care for the poor can no longer be mere verbiage that is subject to contradiction by state governments. To be poor in Georgia, Texas, Ohio, California, New York, Vermont, or Utah is to be poor in America and no state should be allowed to seek economic advantage by forcing its poor to attain health care by moving to another state.

Second, we agree with the concept of a Medicaid Buy-in along the lines creatively proposed by Senator Chafee (R-RI). This would be totally consistent with the Congressional efforts towards welfare reform and with the need to assist many who are employed in cyclical or migrant labor jobs.

C. Appropriateness

The more employers gain expertise in health care data analysis, the more they recognize the billions of dollars that are wasted in the private and public sectors through the purchase of inappropriate and unnecessary care.

The current flurry of attention to quality of care, a welcome shift away from the over emphasis upon unit price, has made employers increasingly aware that the number one target of quality and cost management should be establishment of standards to avoid care that, no matter how well performed, was not needed in the first place. We urge government to use the pressure for expanded benefits for the uninsured to make the investment, in both research and political will, to foster specifications for quality that

can be used by all purchasers to advance the cause of appropriateness.

D. Cost Management and the Limitations of Choice

There is much that has been learned over the past decade about employer cost management programs. Any new effort to create either public programs or private mandates for the uninsured should provide explicit incentives for the use of this technology. One lesson that is increasingly understood by the leading employers, is that the opportunity to purchase high quality, appropriate and efficient care is dependent upon limiting the choice of beneficiaries to getting care from the providers who meet these criteria. Any legal barriers to these limits on choice, or a failure to have the political backbone to stand up for allocating tax dollars only to those providers who pass the standards of excellence, will guarantee an expansion of cost that will far exceed the expansion of needed care for these who are now uninsured.

E. Mandates

Employers are totally opposed to the mandates which create instant markets for providers whose services have not received market acceptance. At the same time, there is growing appreciation for the wisdom of having categories of care (prenatal being the most prominent) included in all benefit plans...not because of the needs of providers but because there is evidence of the inherent value for patients as well as the cost efficacy of good plan design.

At the federal level, employers are divided on the issue of mandates. Philosophically, most are opposed while an increasing number endorse the more basic philosophy that everyone should have access. Economically, most large employers and also thousands of small employers provide benefits that are comparable to or greater than those being discussed for the basic benefit. However, the coverage of part-time workers at 17.5 hours and the requirement that cost sharing with dependents be limited to 80-20 continues to be the largest barrier to major employer acceptance for the mandate approach. These features would add millions of dollars of new costs to the employers who have already done the most voluntarily, and do so at the very time when U.S. industry is most threatened in the global marketplace.

F. Long Term Care

Thanks is no small measure to the excellent work done by Senator Mitchell, this committee is certainly aware of the basics about long term care. Employers, especially the very large ones, are actually doing a lot more in this area than is generally recognized. According to recent research published by the WBGH Institute on Aging, Work and Health, while few employers provide anything called long term care (LTC), a great many have added expanded home health benefits, hospice, respite care, drug coverage for the elderly, case management for the disabled of all ages, and elder care programs for working family members. WBGH has created an Institute for Rehabilitation and Disability Management, sponsored by our members and with projects supported by the Dole Foundation, Department of Education, Social Security Administration, and many corporate foundations. IRDM is structured as a cooperative effort with the National Rehabilitation Hospital here in Washington. Together, they are in the forefront of assisting employers in the design and evaluation of many long term care programs.

Despite this progress, we know that America needs a comprehensive approach to LTC. We do not need a home care only program any more than we need a nursing home care only program. We do need LTC that respects dignity, stresses prevention, recognizes the impact of depression among the elderly, is integrated with acute care for all ages, incorporates the best of case management to, for example, facilitate care for patients with AIDS.

LTC will require a different strategy for people of different ages. For those already 70 and beyond, the issue is really not one of insurance but rather of providing needed services that are integrated with existing acute and catastrophic benefits. For those aged 40-70, a combination of preventive services, asset accumulation or transfer incentives/barrier removals, and actual insurance can be designed. For those in the workforce but below age 40, LTC insurance can be integrated with existing benefits and supplemented by asset accumulation assistance. Finally, future generations can be assisted by having an automatic LTC rider, which cannot be refused, tied to any number of financing vehicles such as school based health insurance, savings accounts, life insurance plans etc.

We provide these thoughts on LTC because one of the most important aspects of the uninsured issue is preventing the growth of this population in the years ahead.

G. Other Social Benefits

One aspect of employer opposition to mandated health benefits or other obligations to pay for the uninsured, is the economic pressures anticipated from other congressionally desired benefit increases such as the minimum wage and the parental leave bill. There are creative ways these issues could be combined. For example, companies that do not now provide health insurance could be allowed an offset against all minimum wage increases in proportion to the extent of new health coverage they agree to provide. In the case of parental leave, should the Kennedy type mandate become law, the dependent cost sharing requirement could be reduced if the employer provided the basic parental leave benefit. Many other approaches can be conceived. The point is simply that the committee needs to understand that employers no longer see all these issues, and the plight of the uninsured, as separate. The best employer response will be earned by the most creative and sensitive Congressional proposals.

Conclusion

We appreciate the opportunity to testify today. America's employers are already paying for a significant portion of the care provided to the uninsured. Employers who have done the most are increasingly willing to seriously consider legislative approaches to more equitably distributing the economic load. This hearing has contributed to an essential dialogue in solving a very serious problem facing our nation.

Opening Statement of Senator John Heinz (R-PA)

Finance Subcommittee on Health

July 25, 1988

Mr. Chairman: Thank you for calling this hearing today. It is critical that the Finance Committee begin to look at the problems faced by those 37 million Americans without health insurance so that we can work to address their needs. For some time now I have been very intereted in expanding health insurance, and have discussed a broad range of options with a working group composed representing the interests of business, labor, insurance, and the Federal Government.

Although the growing uninsured population present us with a very complex problem, it has become clear to me that the problem really boils down to a simple proposition. If everyone had 1) access to adequate health insurance on roughly the same terms and 2) the resources to purchase that coverage, we wouldn't have a problem. I believe that our first focus should be on the question of availability.

Health insurance is not truely "available" when it can only be purchased at very high prices. Health insurance is expensive, there is not doubt about it, and I am not talking about $200-a-year policies. However when studies show that small employers pay as much as 40 percent more for identical packages of benefits as large employers, I think it is reasonable to say that insurance is not readily available to small groups.

This point was made quite dramatically to me at the hearing I chaired in this Subcommittee in Wilkes-Barre, Pennsylvania several weeks ago. One of the witnesses, Joan McNaney, told of the difficulty their small family farm had in purchasing insurance coverage. Her father-in-law ran the farm with her husband and one other employee. When they sought health

insurance, they found that the business was to small to qualify for "group" rates. What the family could afford at individual prices was woefully inadequate and left them with hugh unpaid medical bills when their 12-year-old son needed emergency surgery. We cannot assume that all of the employers who are not currently providing health benefits for their workers simply don't want to. No one would accuse Mr. McNaney's father of not wanting his grandchildren to have the health insurance that they obviously needed to get care.

We must find a way to make health insurance available to everyone at a reaonable rate. I am particularly concerned that small businesses and those families not connected with the workforce, such as early retirees, have the chance to buy health care at the same rate as large companies before we consider proposals that would force them to buy coverage -- no matter what the cost. I am interested in hearing from the witnesses on just what might work in this area, such as pooling arrangements for small employers, making managed care options more available, an the like.

I am also very concerned that everyone has access to a health insurance policy, regardless of their health status. I am hopeful the witnesses can give us guidance as to why many individuals and small groups are denied insurance because of their poor health status, or the high risk of health problems,a dn why others are offered policies that don't cover the very medical services they desperately need. I am particularly interested in what steps might help us in this area -- risk pools? community rating? open enrollment?

Mr. Chairman I commend you for calling this important hearing. I look forward to today's testimony and to continuing to work with the other Members of this Subcommittee on this very important issue.

Statement of

William S. Hoffman, Ph.D.
Director, Social Security Department
International Union, UAW

on the subject of

THE UNINSURED

Mr. Chairman, my name is William Hoffman. I am Director of the Social Security Department of the International Union, UAW. I appear before you today on behalf of some 1.5 million active and retired members of the UAW and their families.

The UAW appreciates the opportunity to present our views on the very important issue of the uninsured. The UAW commends you, Mr. Chairman, for your leadership in addressing one of the most serious social problems facing this nation: the lack of health insurance coverage for millions of Americans and their families.

The Problem

A substantial portion of the population lacks access to even minimal health care services. Today, 37 million Americans, approximately 16 percent of the population, lack public or private health insurance coverage. Twenty-seven percent of the population — more than one person in four — is without health care coverage for at least part of the year.

Significantly, about three-quarters of the persons without health insurance coverage are working men and women and their dependents. Although the majority of employers provide their employees with health care protection, a growing number of employers do not offer any health insurance coverage.

In addition to the decline in employer-sponsored health coverage, there have been substantial cutbacks in the Medicaid program. Presently, those with family income below the federal poverty standard may not qualify for Medicaid benefits if they are not in families with dependent children, disabled or otherwise categorically eligible for Medicaid. In 1984, the median level of qualifying income for Medicaid benefits was

48 percent of the federal poverty level. Only 42 percent of the nonelderly population living in poverty qualified for Medicaid (EBRI Issue Brief, May 1987).

The UAW is deeply concerned about the erosion of the Medicaid program and the impact it is having on the health status of this nation's children. In 1986, Medicaid served 200,000 fewer children than in 1978 when there were nearly 25 percent fewer poor children. Medicaid now serves less than half of all poor children annually. Thirty-two percent, or 11 million, of those without basic health care coverage are children.

Black Americans and other racial minorities continue to experience markedly higher rates of death and disease than whites. The infant mortality rate in this nation is one of the highest of all industrial nations and the death rate among non-white babies in the United States is 70 percent greater than for whites.

Today, there are not enough doctors in rural areas and inner city neighborhoods. At the same time, dollars are wasted on excess hospital beds and duplication of expensive "state-of-the-art" equipment, while more doctors than are needed work as highly paid specialists in affluent suburban areas.

These problems raise serious questions about the lack of financial and geographic accessibility to health care services in this nation. It is simply unacceptable for a nation that has consistently been a world leader in advancing modern medicine to allow so many people to be denied access to adequate health care services. Too often individuals are forced to postpone or do without needed medical care because limited family income must be used for food, housing, or other basic needs. In addition, the lack of health insurance coverage ultimately increases total health expenditures because individuals are forced to rely on hospitals (particularly public hospital emergency rooms) for medical treatment, instead of using preventive and other types of more cost-effective medical services.

Many of the problems we currently face in providing health care for the uninsured have been aggravated by the increasing corporatization of medicine and the present Administration's approach of promoting growth of the for-profit sector in health care.

Public hospitals and not-for-profit community hospitals traditionally have provided a significant measure of charitable care for the uninsured. A recent study in the New England Journal of Medicine which examined the differences in uncompensated care among hospitals in five states found that in four of the states, the amount of unreimbursed care provided by public and not-for-profit hospitals in 1984 and 1985 was 50 percent to more than 100 percent greater than the unreimbursed care provided by for-profit hospitals. Thus, the growing number of for-profit hospital chains has severely reduced social subsidies for the poor and uninsured. As a result, many individuals who are not able to pay for care must live in fear of serious illness or accident.

At the present time, uninsured persons usually wind up being treated as uncompensated care by hospitals and other health care providers. The cost of providing this "uncompensated" care, which is estimated to be about $8 billion (EBRI Issue Brief, May, 1987), is not fully absorbed by hospitals and other providers. Instead, it is passed on to other private payers, mostly to unions and employers, who are providing health care protection.

The UAW has also been concerned about situations where a worker does not receive any health insurance coverage from his or her own employer, but instead is covered by a spouse's employer-sponsored health insurance. In such cases, the health care costs associated with the worker are directly shifted from one employer to the other. This type of cross-subsidization between employers is unfair and inefficient. Employers should not be allowed to shift the cost of providing basic health protection for their employees to other businesses.

The skyrocketing cost of health care has adversely affected the international competitiveness of businesses and has threatened job security for millions of Americans. For example, in Canada, health care costs for employers are approximately one half of the costs in the United States. This provides an incentive for multinational corporations to transfer more production and plant investment outside this country.

The Solution

Mr. Chairman, such an array of difficult and interrelated problems can be

addressed only by the enactment of a universal and comprehensive national health insurance plan. Every industrialized nation, with the exception of the United States and South Africa, has found it politically, economically and socially practical to adopt a national health security program. Individuals in Canada, Great Britain, Sweden, West Germany, Italy and other countries are guaranteed basic health protection by law. American citizens should also have this same protection by law as a basic social right.

The UAW has been a leader in the fight for a national health insurance program. We remain committed to this goal, and are confident that it will be achieved.

The UAW has represented workers in Canada for many years, and our experience with their national health care program has been very positive. The Canadian system, which is based on a federal-provincial partnership, provides comprehensive health insurance coverage to all citizens in a cost-effective manner. Whereas the United States currently devotes over 11 percent of its Gross National Product to health care, Canada only spends about 7.5 percent of its Gross National Product on health care. Drawing from the Canadian experience, the UAW believes that it would be worthwhile to explore whether comprehensive health insurance benefits can be provided to all Americans through a program that would have federal standards, but which would be implemented and administered by the states.

The UAW commends Governor Dukakis for his leadership in enacting the Massachusetts Universal Health Care bill. This landmark legislation provides universal access to health care insurance for all residents of Massachusetts. Under the legislation, most employers will be required to provide or pay for the costs of health-insurance coverage for their workers and their families. In addition, a state fund will provide health insurance to individuals not covered under employer-sponsored health plans, including the unemployed and certain functionally impaired individuals who are without health care coverage. The UAW urges similar action in other states. Ultimately, however, we believe such a program needs to be implemented on a national level.

Although our support for a national health security program continues unchanged, we recognize that we have an opportunity at the present time to encourage legislative

initiatives that will provide greater access to health care for millions of Americans. Senator Kennedy and Representatives Waxman, Clay and Murphy have introduced the proposed "Minimum Health Benefits for All Workers Act of 1987" (S. 1265; H.R. 2508), which would require all employers, as a condition of doing business, to provide their workers and their families with at least a minimum level of health insurance benefits. More recently, Representative Stark has introduced the proposed "Employee Health Benefits Improvement Act of 1988" (H.R. 4951), which would basically accomplish the same objective by imposing an excise tax on any employer that fails to provide a minimum level of health insurance benefits to their workers and their families. We understand, Mr. Chairman, that you have also been considering similar proposals.

The UAW strongly supports the basic thrust of these bills. Regardless of the enforcement mechanism (Fair Labor Standards Act, Public Health Act, or Tax Code) we believe that all employers should be required either to provide a minimum level of health insurance benefits directly to their employees and their families, or to pay a tax to the government to cover the cost or providing these health insurance benefits through a government sponsored program.

Such legislation would accomplish two important objectives. First, and most importantly, it would significantly improve access to needed health services and thus improve the health of millions of Americans.

Secondly, this legislation would substantially reduce the unnecessary, inefficient, and unfair cost-shifting that takes place in our present health care system. This would result in substantial savings for the federal government and to the majority of employers who currently provide health care protection.

To accomplish the twin objectives of expanding access to health care and reducing unfair cost-shifting, the UAW believes it is essential that three basic elements be retained in any legislation:

* All employers must be required to provide or pay for a minimum package of health insurance benefits for their workers. There cannot be any exceptions for small businesses or particular types of employers;

* All workers (including part-time employees working 17.5 hours or more per week) must be covered under the minimum package of health insurance benefits;

* The minimum package of health insurance benefits must also provide coverage for spouses and dependent children.

The UAW also supports a number of other provisions in these bills. In particular, we strongly support the provisions that would pre-empt all State laws requiring health insurance plans to offer specific benefits or to include particular types of health care providers. The UAW applauds the provisions prohibiting denial of benefits for pre-existing conditions. And we commend the sponsors of the legislation for including provisions which will allow small businesses to obtain coverage at more affordable costs.

The UAW supports the provisions in H.R. 4951 which require continuation of coverage for laid-off workers and which allow employee benefit plans to be selective in types and numbers of providers. We support the concept in S. 1265 whereby employers may satisfy their obligation by providing an actuarially equivalent benefit package.

The UAW recognizes that some elements of these bills will require further refinement. For example, we believe that the minimum benefit package proposed in the bills should be improved, and that employers should be required to pay for 100 percent of the premium cost for all workers. The UAW looks forward to working with the sponsors of the bills on these and other matter as they move forward in the legislative process.

We recognize that some persons may critize these bills as being "anti-business". That is simply not true. The overwhelming majority of employers who currently offer health insurance benefits to their workers will not have to shoulder any additional burdens under the bills. In fact, they will enjoy significant cost savings by virtue of the reduction in cost-shifting among employers, the premption of state mandated benefit laws, and the establishment of regional or state pools that will be able to offer insurance coverage at more affordable rates.

Some opponents of these bills have objected to the notion of the federal government "mandating" employee benefits. But clearly there is ample precedent for

the federal government to take such action. Our society has already mandated that employers provide or pay for a minimum wage, contribute to minimum retirement income, disability insurance and basic protection against loss of income due to layoffs (through Social Security and Unemployment Insurance). We have also imposed minimum occupational health and safety and pension funding standards on employers. In line with these precedents, it is now time for the federal government to mandate all emloyers to provide or pay for a minimum level of health insurance protection for workers and their families.

I would like to emphasize, Mr. Chairman, that the approach incorporated in these bills is essentially a private sector solution. The bills do not call for increased government expenditures. In fact, they would save money for the federal government. The bills basically seek to require the private sector to step up to the responsibility of providing adequate health insurance protection to workers and their families. There is no justification for letting employers escape from this fundamental responsibility. To allow a small minority of employers to continue to evade this responsibility is unfair to the federal government, to other employers, as well as to workers and their families.

The Health Insurance Association of America has recently developed a proposal which would attempt to expand access to health insurance through a "voluntary" private sector approach. This proposal would basically encourage employers to offer health insurance benfits through a combination of tax and other incentives (such as exempting basic, low cost health insurance plans offered by insurers from state mandated benfit laws). This approach is doomed to failure. Under any "voluntary" system, a substantial number of employers will always decide not to offer any health insurance coverage. No matter what incentives are offered, it will always be cheaper for employers not to offer any benefits. Thus, a substantial number of workers and their families will still be without access to health insurance benefits, and the health care costs associated with these individuals will still be shifted unfairly onto the federal government and other employers.

In addition to the minimum health benefits legislation, the UAW also strongly supports the expansion of Medicaid coverage to include all persons living in households

with incomes below the federal poverty level. The states should not be allowed to apply different criteria in determining eligibility and the types of services provided to persons below the poverty level. The United States General Accounting Office (GAO) reported that between 1980 and 1986, out-of-pocket medical costs have increased substantially for the poor. This has been largely a result of Medicaid cutbacks. It is unconscionable to permit the states to exclude so many impoverished women, infants and elderly people from eligibility for Medicaid benefits.

Finally, recognition of the serious plight of the uninsured has led to a number of voluntary efforts on the part of community leaders, labor unions, and provider groups around the country to provide some health care services for the uninsured. There have also been a number of initiatives at the state level to increase accessibility to health care for those unable to purchase adequate health insurance coverage. Fifteen states have established state comprehensive health insurance associations, sometimes referred to as risk sharing pools. These state subsidized health insurance pools offer an alternative for persons unable to purchase coverage from other sources.

The UAW commends those states that have established risk pools and encourages all states to take such action. Such pools should cover the unemployed, so-called "uninsurables", and retirees of bankrupt companies who have lost their health insurance coverage. However, a coordinated national health program would be a more effective means of providing coverage to these groups of the uninsured.

The UAW is committed to making quality health care services available to those who have traditionally been excluded: the impoverished, the unemployed, racial minorities and the functionally impaired. As a nation we must begin to address these significant concerns. Every day we delay makes the task that much greater.

Positive approaches are needed that will effectively address the fundamental issues of access to quality health care services. Approaches are needed that:

- address unmet health care needs;
- expand coverage;
- remove barriers to access;

- promote quality;
- remove discrimination;
- rehumanize the health care system to put peoples' needs first;
- reign in costs and budget appropriately.

Mr. Chairman, a national health insurance program will ultimately be needed to address the many vexing problems of the health care system. It is not too late for the United States to join the rest of the modern world in providing universal health care protection.

Mr. Chairman, the UAW applauds the leadership that you have provided in efforts to make our health care system more equitable and effective. We appreciate the opportunity to present our views on the uninsured in these hearings. Thank you.

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STATEMENT OF

RICHARD N. JENSEN

SENIOR STAFF ASSOCIATE
FOR HEALTH POLICY

Representing the

NATIONAL GOVERNORS' ASSOCIATION

Good afternoon Mr. Chairman, members of the subcommittee. I am Richard N. Jensen, the Senior Staff Associate for Health Policy of the National Governors' Association. I am pleased to be testifying before you today regarding state activities to deal with the lack of health insurance for millions of our citizens; a problem that has been a concern of the Governors for some time.

Let me begin by saying that I am here today to provide information on state activities in addressing the problem of the uninsured. The NGA is in the process of developing policy to address this problem, and will be prepared at the beginning of the next Congress to provide specific recommendations regarding proposed legislation.

The number of people with no health insurance in the country today is approximately 37 million. Many more have limited insurance coverage which leaves them financially vulnerable. The majority of the uninsured are employed, and/or dependants of employed workers. yet these people either have no employer-sponsored insurance offered to them or do not have enough money to pay the premiums on the insurance offered. Some of the uninsured are the so-called "uninsurable," people with chronic health problems that prevent them from obtaining insurance. Finally, there are unemployed, low-income individuals who do not qualify for Medicaid or other public assistance programs.

The population without insurance is not homogeneous. The reasons for their situation differ, and the solutions to their problems will vary.

The lack of health insurance for so many Americans is a significant barrier to healthy self-sufficient lives. It places low-income families at risk financially and limits the amount of health care vulnerable members of our society, particularly children and pregnant women, receive. It will take a concerted efforts on the part of both the public and private sectors to alleviate this situation.

The approaches to alleviate the problem can be classified under three broad categories:

- Medicaid expansions;
- State alternatives;
- Private sector alternatives.

Many states have already begun to experiment with these approaches to varying degrees. In some states, both public and private sector solutions have been pursued. Often a combination of policy initiatives will be the most effective approach to a particular state's situations. While the states do not have all the answers, we are encouraged by the creative and exciting efforts to date.

Let me review the policy options available to states and some examples of state activities.

Medicaid Expansions

The Medicaid program is usually the first alternative both states and the federal government pursue when considering the problem of the uninsured. Medicaid is the primary insurer of the poorest families and individuals in our country, and it's a program with which we are familiar.

One basic way Medicaid can be used to cover more people is by raising the eligibility levels for the Aid to Families with Dependent Children (AFDC) program. Such an increase extends the Medicaid program to a broad group of the poor because families eligible for AFDC are automatically eligible for Medicaid. However, with the budgetary limits many states are facing, more selective expansions have been pursued.

The most frequent Medicaid expansion pursued by states is the expansion of service coverage to children and pregnant women with income below the federal poverty level, with the authority provided by the Omnibus Budget Reconciliation Act of 1986. To date, 42 states are providing coverage to infants and pregnant women below the federal poverty level. In addition, 10 states are considering implementing the provision in the Omnibus Budget Reconciliation Act of 1987 that allows coverage for infants and pregnant women up to 185 percent of poverty.

Another way in which states have broadened their service coverage in Medicaid is by instituting medically needy programs. Between 1981 and passage of the OBRA-86 provision, seven states had adopted a medically needy program, three for children and pregnant

women only, and four for all Medicaid eligible groups. This is in addition to the 30 states which already had medically needy programs. Since OBRA-86, all but one of the states have retained their medically needy programs, because such programs offer the recipient a safety net of coverage when they face high medical costs. The OBRA-86 provision creates a categorical eligibility group, but that does not provide much of a safety net since eligibility is based on a persons income prior to incurring any medical expenses.

Another expansion to Medicaid has been proposed by this committee in the welfare reform bill (S. 1511). This is a transitional Medicaid benefit for families leaving the welfare rolls and entering the work force. The Senate proposal provides a one year extension of health care benefits to families who leave the welfare rolls and find employment. During the second six months, states would be allowed to offer different plans as alternatives to Medicaid, and would be required to charge the beneficiary a premium for the coverage.

This proposal would, for the first time, allow states to use Title XIX funding for something other then the approved state Medicaid plan (e.g., subsidize the premium for employer-sponsored insurance), and to charge recipients a premium. Such a change has broad implications. Using Medicaid funds in this way could be applied to a much broader population of the uninsured than just those recently off of the welfare rolls.

Another way in which states act to indirectly cover the uninsured through the Medicaid program is through compensation to hospitals with high amounts of bad debt. This is done by paying a higher reimbursement rate to hospitals that qualify as having a high, or disproportionate, share of low-income patients. The Medicaid program requires that state plans allow for such compensation.

State Sponsored Plans

There are several options states can pursue besides those presented by Medicaid. One is to create a general assistance program for those people with low incomes that are not eligible for AFDC (e.g., single adults) and provide them with health care benefits.

Another alternative is the use of financing pools. Financing pools are entities that retain revenues contributed by many sources to be used to pay for the health care costs of those who contributed. They spread the individual liability of each

contributor among the entire group, thus minimizing the liability any one individual faces. Financing pools, of which there are different forms, allow for the pooling of dollars, persons or types of services paid. Financing pools have been established by the public sector in areas where no private insurers have provided coverage.

Pooling has been used by some states to establish risk pools for people with chronic medical conditions that prevent them from purchasing regular group or individual insurance. Fourteen states have authorized such pools although only seven have appropriated funds for them. The common model for these pools is to have individuals in need of such insurance pay a premium that is higher than a premium for a standard group plan but capped at a set level. To the extent the pool cannot meet the expenditures needed for the high risk population, the state contributes to the fund.

Financing pools have recently been viewed as a method of providing insurance to the low-income uninsured. In this model, the state sets up a pool to insure individuals and families with no other insurance, and collects premiums on a sliding scale based on income. The state appropriates funds or seeks other funding sources to pay the costs not covered by the premium.

Some states have established financing pools to pay for the cost of uncompensated care. Such pools are designed to provide a source of funding for the bad debt many hospitals face, particularly those with a high volume of low-income individuals.

Private Sector Alternatives

Employer-sponsored health insurance is the way most Americans receive their health care coverage. It is a well-established and effective means of coverage when it is made available. Any effort to provide insurance to the uninsured should include a role for employer-sponsored insurance. The public sector alone must not be viewed as the only solution. Private sector coverage should be expanded and improved.

There are several ways in which the private sector, particularly small businesses, can be encouraged to provide health insurance to their employees. One is to mandate such coverage. Another is to provide tax incentives and disincentives. The mandate is a very straight forward approach to gain coverage for all employees and their dependents, and would potentially cover two-thirds of the currently uninsured. The argument against such a mandate is that it imposes a substantial financial burden on small business and may force many of them to go out of business.

To the extent the public sector becomes involved in encouraging the private sector to expand its coverage of individuals, there is one major factor that has to be considered. The Employee Retirement Income Security Act (ERISA) preempts any state regulation of self-insured entities. Fully 50 percent of the country's business sector now self-insure. For this reason any action taken at the state level, whether it is a mandate to provide insurance or some other requirement, has significant limits. Either ERISA would have to modified to allow state oversight of self insured businesses, or the federal government would have to make the changes.

Tax incentives and disincentives give employers the option of providing health insurance to their employees. Employers that fail to do so would pay a higher tax, while employers who provide coverage, particularly small employers, might be provided with tax incentives (e.g. credits) to do so. Under such a plan the additional revenues would be used to establish health plans (or pools) which uninsured workers could buy. Thus, whether through their employer or the state plan, all employees would be insured.

Whether a mandate or tax incentive system is used, an important consideration is the creation of multiple employer trusts (another form of financing pools) for groups of small employers to join. The purpose of multiple employer trusts is to spread out the liability faced by small employers that is nearly equal to a group insurance plan. The obvious result is costs equal to group insurance plans. This limits the financial impact on small businesses and thus eliminate their primary concern with such proposals.

State Examples

There are numerous projects being developed and pursued in the states. These projects have incorporated some of the options described above, often more than one. The states are laboratories for improving the access of the uninsured to health insurance. Many of the state programs are supported by funds from a project of the Robert Wood Johnson Foundation that is cosponsored by NGA.

Maine is currently developing a new insurance plan that targets both AFDC Medicaid enrollees and uninsured low-income people. This managed care plan provides comprehensive acute and primary health care services. Financing for the program (along with Robert Wood Johnson funds for planning) comes from a combination of Medicaid payments, state appropriations, employer and employee payments and hospital charity care payments. By having a large group of contributors, Maine hopes to spread out the costs of covering the uninsured to make it more affordable for employers to provide coverage for employees. The linkage between continued Medicaid coverage for former AFDC clients and this new program is expected to encourage work through uninterrupted health care

coverage. The pilots are being operated in one rural and one urban county.

In **Michigan**, a citizen advocacy group working with the Department of Social Services and Robert Wood Johnson support have a pilot project to increase access for the uninsured. One part of the project will extend medical assistance for four months for individuals leaving general assistance. The second, and more significant part of the program, is the one-third share plan. This program encourages employers to offer health insurance to their employees by providing a subsidy from the state. Employers qualify by hiring at least one former Medicaid or general assistant client. The state then offers to cover one-third of the cost of the health care coverage for all of the business' employees, with the employer and employees each contributing one-third of the cost. The program, begun in May, is being run in one urban and one rural county. The test for the program is whether the subsidy of one-third of the cost is enough to encourage employers to support such a plan.

Over the next year the state of **Washington** will implement the Basic Health Plan for the uninsured at five pilot sites aimed at providing coverage to 30,000 low-income residents. The program will emphasize primary and preventive health care, including prenatal, post-natal, and well-child care. Under this initiative the state will contract with private health plans to offer a prescribed package of benefits on the basis of competitive bidding. Any uninsured person in the pilot sites whose income is less than 200 percent of the poverty level is eligible for the program. The individual will pay a premium based on their income, as well as co-payments for certain services. The program will be financed with state appropriations and premiums paid by the participants. It is Washington's intent that these plans work smoothly with the Medicaid program in these areas by having the same contractors for the Basic Health Plan as for Medicaid. This coordination of health plans will eliminate any disruption for the individual or family as their financial status changes. This entire effort is also being coordinated with the state comprehensive welfare reform project, the Family Independence Program.

Probably the most ambitious state program is now being implemented in **Massachusetts**. Massachusetts is phasing-in a comprehensive system of health care coverage which guarantees access to coverage to all its residents by the year 1992. The new program incorporates a variety of policy initiatives, but the most innovative feature is the use of tax incentives and sanctions to encourage employers to provide health insurance for their employees in an effort to target the Commonwealth's employed uninsured

population. All employers with more than five employees will be required to pay a surcharge for each of their employees to a state health insurance pool through which employees can purchase coverage. Those employers who already provide health benefit plans to their employees can deduct the costs of these plans from their surcharge. However, if they choose not to provide benefits, their employees will still have access to insurance through the pool.

Because small businesses may have greater difficulty paying the premiums for the coverage, a pool (multiple employer trust) will be created for employers with six or fewer employees so they can secure lower rates, and a hardship fund will be established to pay surcharges exceeding 5 percent of an employer's gross revenue for small companies. In addition to adopting the employer incentives, Massachusetts also established an uncompensated care pool to help offset health care providers for the provision of bad debt and charity care, expanded Medicaid, established health care programs for General Relief recipients, and set up insurance programs with sliding scale fees for the remaining uninsured in order to make the system comprehensive.

Thank you for inviting NGA to testify before you today. I hope this information will be of assistance to you. We look forward to working with the subcommittee as deliberations on this important issue continue.

STATEMENT OF DR. CAROL M. McCARTHY

Mr. Chairman, I am Dr. Carol M. McCarthy, president of the American Hospital Association. I am pleased to have the opportunity to be here today on behalf of the AHA's more than 5,300 member institutions and 40,000 personal members to discuss with this subcommittee the issue of access to health insurance in the United States and the problems resulting from the lack of health insurance coverage.

Nationally, 37 million Americans are medically uninsured, millions more are underinsured, and the number of medically indigent grows every year, in good economic times as well as bad. Hospitals strain to meet the needs of the medically indigent with the current bill for indigent care topping $7 billion. While the uninsured eventually receive care, they tend to seek too little, too late. They come to deliver their babies, but do not seek prenatal care; they come to our emergency rooms with serious illnesses that could have been treated less expensively a year earlier. They come to us after they have depleted their few economic resources to pay for care, thereby assuring that they will have no resources to recover from the financial devastation of illness.

Much of the rise in the number of uninsured has been caused by the recent deterioration of Medicaid coverage. Medicaid covers 38 percent of the poor population--a decade ago it covered 65 percent. But much of the problem of medical indigence also stems from the erosion of the traditional link between work and insurance; employers have been covering a shrinking proportion of workers and their families.

For this reason, AHA's Special Committee on Care for the Indigent concluded two years ago that an enduring solution to the problem of medical indigence will require initiatives by both public and private sectors to:

- Reduce the size of the medically indigent population through private health insurance; and

- Finance care for the medically indigent who are unable to obtain private insurance through restructured and extended public programs.

Another dimension of the problem of access to health care insurance is long-term care as it relates to the elderly, the disabled and the chronically ill. The Medicare Catastrophic Coverage Act of 1988 focused the nation's attention on problems faced by Medicare beneficiaries and underscored shortcomings of current public and private financing of long-term care. The problem of financing long-term care presents many challenges to our society, and the responsibility for its solution must be shared by all: individuals, the private sector, and state and federal governments.

HEALTH INSURANCE COVERAGE OF THE EMPLOYED

The U.S. health insurance system currently is built on employer-provided insurance. About 85 percent of the 191 million privately insured Americans now receive insurance through the workplace; federal and state tax policies clearly support this pattern. In 1982, federal and state governments provided a $31 billion subsidy of the privately insured through exclusion of employer-paid health insurance from the taxable income of employees.

Nevertheless, 53 percent of the uninsured have a full-year, full-time link to the workplace, and another 34 percent are linked to the workplace on a part-time or intermittent basis. A recent analysis by the Employee Benefit Research Institute shows that, of the 34.8 million non-elderly uninsured in 1985:

- 52.3 percent lived in families headed by full-year, full-time workers;

- 8 percent lived in families headed by full-year, part-time workers;
- 17.2 percent lived in families headed by sometimes unemployed workers;
- 9.2 percent lived in families headed by part-year workers; and
- Only 13.5 percent lived in families headed by nonworkers.

In combination, these statistics lead to two conclusions. First, the favorable tax treatment of health insurance benefits has facilitated high levels of private insurance coverage. Second, even current tax incentives are inadequate to induce a sizable number of employers to offer private insurance coverage through the workplace.

There is considerable logic to the idea of extending coverage to many of these people by building on the existing system. The key policy question is how. Two approaches have been suggested: the use of mandates and the use of tax supports, public subsidies, and other incentives. Both approaches are necessary.

Ideally, AHA would prefer to rely on strong economic incentives and joint private/public-sector action to induce employers to offer insurance to their employees. Many state and local groups are currently experimenting with many bold initiatives designed to facilitate coverage by lowering, and often partially subsidizing, the cost of insurance. AHA this year published a resource guide designed to support such efforts and encourage their replication.

But strong economic incentives and joint private/public-sector action are no longer enough. The growing "crack" in the private and public insurance system has now become an abyss. This crisis calls for immediate, strong action from public programs and the private sector. Yet this outcome is unlikely without a federal mandate. Just as employers must provide a minimum wage and a safe working environment, they have an obligation to make health insurance available to their employees.

For a mandated approach to work, however, employers must have the tools to comply. A workable mandated approach will require:

- Carefully defined mandates, with a minimum amount of regulatory intrusion required to implement them; and
- Inclusion of features designed to minimize economic dislocations caused by the mandate such as:
  - A widely available affordable insurance product;
  - Gradual, phased-in mandates; and
  - Significant tax relief and other subsides.

AHA recently endorsed S.1265, introduced by Senator Kennedy, that would make the provision of health insurance coverage a requirement for doing business, in much the same way that paying a "minimum wage" is a condition of doing business in the United States. Although some have opposed the Kennedy bill on the grounds that it would impose a substantial burden on business, it should be recognized that all Americans pay the cost of inadequate insurance protection. And big businesses, among which private insurance is nearly universal, pay three times: once for their own employees, once for working spouses of those employees, and once for those who are not insured, in the form of higher prices for medical care.

Mandating insurance coverage is a major step toward ensuring access to care and the equitable distribution of the cost of medical indigence. Employer mandates, however, are only part of the answer to medical indigence. If business has an obligation to make insurance available for employees and dependents, government has the obligation to create an environment that will

enable business to comply. AHA urges Congress to strengthen tax incentives to encourage both individuals and small employers to obtain health insurance coverage and to make such insurance coverage affordable.

One very sound proposal for facilitating employer-sponsored coverage is S.2234, introduced by Senator Durenberger. Among small businesses with fewer than 10 workers, only 29 percent of unincorporated "proprietorships" (compared with 70 percent of small corporations) offer a health plan, in part because owners of unincorporated businesses are permitted to deduct only 25 percent of health insurance costs for themselves and their families as a business expense. S.2234 would remove this disincentive by permitting the 100 percent deduction already enjoyed by owners of incorporated businesses.

States also should support private insurer, employer, and provider efforts to develop alternative sources of affordable insurance. Among the options that should be explored are the formation of multiple-employer insurance arrangements and the development, with providers, of financing and delivery systems to effectively manage utilization and costs.

MEDICAID REFORMS

Even if these actions are taken, it is clear that the government will have to continue playing a major role in ensuring that health care services are available to all Americans. As such, public programs to finance care for the medically indigent who are unable to obtain private insurance should be restructured and extended. It is imperative that the federal government fulfill its obligations under existing programs, particularly Medicaid.

Despite recent expansions of state options, the program fails to cover many of the most vulnerable groups. Recent Congressional Budget Office data, for example, show that among unmarried working mothers earning under $3.50 an hour, or about $6,700 a year:

- 24 percent are covered by employers and other private coverage;
- 31 percent are covered by Medicaid; and
- 45 percent are uninsured.

The inadequacy of Medicaid is the primary reason for the gap in insurance for children, particularly poor children. Inadequate Medicaid coverage for individuals with AIDS is another area that deserves the subcommittee's attention. This subcommittee could address these problem by requiring or facilitating reform in eligibility policy, enrollment incentives, financing and reimbursement, and service coverage.

Congress enacted the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986) and the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) that gave states options to expand Medicaid eligibility for the very vulnerable--poor mothers and young children. The Medicare Catastrophic Coverage Act requires states to cover pregnant women and infants up to 100 percent of the federal poverty level. Through these pieces of legislation, Congress has demonstrated its commitment to assist those most in need and has begun to repair much of the damage caused by the earlier erosion of Medicaid coverage of the poor. Even with these changes, however, severe eligibility problems remain, and the program faces significant problems with payment, reimbursement, and service coverage.

Eligibility

The first eligibility problem stems from the fact that mandates under the catastrophic care bill cover pregnant women and infants only; for older children, OBRA 1986 and OBRA 1987 offer options rather than mandates. Whether a particular poor child is covered, therefore, will depend on whether the state has chosen to exercise the option and how aggressively the state chooses to be in its outreach efforts.

Even if all of the states were to enact the maternal and infant care options contained in OBRA 1986 and OBRA 1987, some very serious eligibility gaps and state-to-state inequities would remain. In Alabama, for example, a single mother of two earning $1,417 a year still would only be covered if she were pregnant, and then only for pregnancy-related care. Her children would only be covered if they were under age 8. Her 9-year-old would be ineligible, because the child would be too old for inclusion under the OBRA options and too rich for inclusion under the traditional program. If a 9-year-old lived with both parents in Alabama, the child would lack coverage even if the family income were below $1,417 because Alabama does not cover two-parent families.

Eventually, we must come to terms with the core problem: Medicaid eligibility ceilings are linked to Aid to Families with Dependent Children (AFDC) payment levels, and these AFDC payment levels, in turn, show both tremendous interstate variation and a consistent decline over time. In 21 states, eligibility levels are now at or below 50 percent of the poverty level, meaning that dependent children and their mothers in three-person families earning more than $4,650 a year do not qualify. (Medically needy programs in some of these states raise the income ceiling somewhat but never by more than one-third.)

For these reasons we support:

- Establishment of a minimum national eligibility floor for Medicaid set at 50 percent of the federal poverty level; and

- A phased-in plan for moving the national eligibility floor from 50 percent to 100 percent of poverty.

A final eligibility problem concerns the all-or-nothing nature of Medicaid coverage and the links between welfare and Medicaid. Typically, the entry-level jobs found by former AFDC recipients do not offer group health insurance and do not pay enough for the employee to purchase individual, much less family coverage. But they do pay enough to move the former welfare recipient beyond Medicaid eligibility ceilings. As a result, parents often find they must choose between employment and health insurance for their families. Current federal requirements and state options provide a few months of transitional coverage, but then coverage ends.

As a solution to this problem, we support H.R.4033, introduced by Congressman Waxman, that would:

- Require states to extend, for 24 months, Medicaid or alternate health care coverage to families who lose cash assistance under the AFDC program due to earnings and who continue to work; and

- Give state Medicaid agencies financial incentives to increase program participation.

Welfare legislation currently being considered by House and Senate conferees contains a provision that would provide some transitional Medicaid coverage to working families after they leave welfare. Assuring continuation of health care coverage for them is a priority for AHA. We would urge the conferees to carefully deliberate this issue.

Potentially, hospitals can play an important role to help close this enrollment/eligibility gap through outreach activities. AHA is strongly committed to supporting hospitals in this activity and will provide technical assistance to hospitals and other organizations wishing to play this role. We would be very interested in working with this subcommittee to devise cooperative strategies for facilitating enrollment.

Financing and Reimbursement

For states to expand eligibility, more money must be brought into the system. Medicaid programs already are staggering under the burden of financing existing health care services excluded under Medicare. Care for the elderly

and disabled, particularly long-term care services, already accounts for three-fourths of Medicaid expenditures. In some states, programs also are absorbing a large and growing share of expenses for AIDS patients. Medicaid currently pays for the care of about 40 percent of the nation's AIDS patients, although in some areas the percentage may be significantly higher. Because Medicaid plays such an important role in financing care for individuals with AIDS, reimbursement rates must be adequate and appropriate. The University of New Mexico Hospital recently reported that it loses approximately $3,000 per admission on Medicaid AIDS patients. A 1987 study by the National Association of Public Hospitals also reported significant shortfalls in reimbursement for Medicaid AIDS admissions nationwide.

In the past several months, AHA has worked with state task forces and study groups to develop cost estimates for the OBRA 1986 expansions. We have seen first hand how states are struggling to finance Medicaid expansion or, in some cases, struggling simply to maintain the current level of commitment. Sometimes they fail. In Illinois and Michigan, for example, hospitals and nursing homes have gone for months at a time with no Medicaid reimbursement because the state Medicaid agency ran out of funds well before the end of its fiscal year.

One way states have reacted to the financing problem is by holding down provider reimbursement, but such a strategy has serious implications for patient access to needed services. When reimbursement levels are too far below levels customarily paid under private plans, the newly eligible often find little improvement in access to care.

The legal foundation for a solution already exists. Section 1902(a)(13)(A) of the Social Security Act requires state Medicaid programs to provide satisfactory assurances to HCFA that Medicaid payment for hospital and long-term care services provided under a state plan are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide care and services in conformity with applicable state and federal laws, regulation, and quality and safety standards. In addition, payment must be reasonable and adequate enough to ensure that individuals eligible for medical assistance have reasonable access to inpatient hospital services of adequate quality. Section 1902(A)(30) of the Act requires that payments be consistent with efficiency, economy, and quality of care.

HCFA regulations have gone into some detail about the kinds of computations and types of proof states must submit to show that they have met the upper payment limit requirements. But there have been no details concerning what states must do to meet minimum reimbursement requirements; i.e., what kinds of evidence states must submit to prove that their rates are, in fact, adequate to ensure access to care.

For expanded eligibility to translate into improved access, there must be clear criteria and procedures for scrutinizing the adequacy of reimbursement rates. For example, certain sections of the Medicaid Infant Mortality Amendments of 1988 (S.2122) introduced by Senator Bradley but not included in the catastrophic law, would strengthen this requirement:

- Adding to Sec. 1902(A)(30) of the Social Security Act a requirement that state Medicaid payments be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population"; and

- Requiring states to submit an obstetrical services amendment to the state plan that specifies, by procedure, the payment rates to be used, so that the HHS Secretary can make a determination as to their adequacy.

Provisions such as these, particularly if broadened to include services beyond obstetrical/infant care services, could go far toward improving access to care. We would welcome the opportunity to work with this subcommittee in developing methodologies and strategies for assuring that reimbursement levels are adequate to ensure access.

Service Coverage

Because Medicaid is a joint federal-state program, with states free to operate within general federal guidelines, state programs can and do vary considerably not only on the extent but also on the content of coverage. Federal rules on covered services mandate certain services for the categorically needy and a different list for the medically needy; they leave other coverage decisions to states' discretion. Moreover, the law permits states to limit the amount or scope of required as well as optional services.

This patchwork Medicaid system results in gaps and voids in which necessary and cost-effective services are not covered. In particular, this system often makes it difficult for states to implement cost-effective mechanisms for addressing the catastrophic and chronic care needs of population groups such as children or individuals with AIDS. For example, Medicaid traditionally has not paid for case-management services, or for many of the support services necessary to maintain a disabled child or an AIDS patient in the community. There have been some recent positive developments along these lines, however, and we believe this progress could be accelerated through additional steps taken by this subcommittee.

States have shown great success in using a waiver option (Sec. 2176) for disabled children and adults alike, which allows for provision of home- and community-based services to Medicaid recipients who otherwise would require institutional care. However, currently only three states with the 2176 waiver specifically target home-and community-based services to individuals with AIDS. Many states have been reluctant to seek a waiver because of the difficulties involved: they must prove that the estimated home care costs are lower than estimated institutional costs, and they also face limits in terms of the total number of people who can be served under a waiver.

Given the proven cost effectiveness of community-based care for many groups currently receiving expensive institutional care under Medicaid--AIDS victims and the elderly, as well as disabled or chronically ill children--this subcommittee might wish to consider replacing the 2176 waiver provisions with a straightforward state option allowing for such substitutions.

In addition, when properly done, case management can improve quality of care and reduce costs. The case manager assists the client in developing and appropriate plan of care, reevaluates the plan as necessary, helps to locate and coordinate needed services, and provides follow-up. These services are particularly useful in the case of disabled or chronically ill children and adults who are likely to need frequent care from many providers.

Congress recently gave states the option of paying for case-management services in their Medicaid programs and also permitted states to target this service to subgroups within the Medicaid population. However, it does not appear that this option is widely known. One way to encourage states to exercise this choice would be to provide an enhanced federal match. Therefore, this subcommittee might consider a federal match of 80 percent or even 100 percent for case-management services.

Any comprehensive approach to the problem of medical indigence must begin with Medicaid reform--reform not only of state eligibility standards but of payment, reimbursement, and coverage as well. We have seen some important gains in the past few years; much remains to be done.

LONG-TERM CARE

Ensuring that all Americans have access to at least a minimum amount of health care coverage would still leave thousands of families with the threat of financial disaster should they face a catastrophic illness or injury. Although the Medicare Catastrophic Coverage Act of 1988 eliminates this fear for acute care expenses of the Medicare population, it fails to adequately address the potential for financial ruin resulting from the long-term care needs of Medicare beneficiaries and others.

The responsibility for financing long-term care has been, and probably will continue to be, shared by all segments of society. We must encourage individuals to provide for their long-term care needs to the extent permitted by their income as a way to shield themselves from catastrophic expenses of chronic illness. In addition, we must ensure access to long-term care when individual resources are inadequate and establish a more humane alternative to "spend down" requirements as a precondition for eligibility under public programs. People should not have to waste what limited assets they may have simply to qualify for limited government assistance.

Specifically, AHA has previously recommended:

- The development of private-sector alternatives for financing long-term care, encouraged through tax incentives and demonstration projects supported by both the public and private sectors;

- An increased emphasis in public programs on the development of alternative methods of delivering care that keep those with chronic illnesses out of institutions, when appropriate; and

- The adoption of alternatives to the current Medicaid "spend down" requirements to prevent the further impoverishment of the dependents of those with chronic illness.

CONCLUSION

Assuring access to health care for uninsured Americans is one of the most pressing problems facing our society today as more and more people fall through the cracks of the private and public insurance system. Solutions can only be found through cooperative efforts of the public sector, including federal state and local governments and the private sector.

Toward this end the American Hospital Association recommends:

- Combining federal mandates and tax incentives and other subsidies to make employer-provided insurance available to all workers;

- Reforming Medicaid eligibility policy, enrollment incentives, financing and reimbursement, and service coverage to help the federal government meet its obligations to those who cannot afford insurance; and

- A public- and private-sector sharing of the responsibility to assist Americans in providing for their long-term care needs.

We applaud your efforts thus far to address many of these problems and urge your continued focus. We stand ready to assist you in any possible way. It is only together we will be able to patch up the holes in the health care safety net.

OPENING STATEMENT

SENATOR GEORGE J. MITCHELL

HEALTH INSURANCE FOR THE UNINSURED

SUBCOMMITTEE ON HEALTH

JULY 25, 1988

Welcome, today we will begin our examination one of the most serious problems we face in health care in this country. This is the problem of the the many people in this country without health insurance and, therefore, limited access to essential medical care.

There are 37 million people in this country without any health insurance; public or private. One third of these people are children. Almost two thirds are low income or poor. Many are people with pre-existing medical conditions who despite a reasonable income cannot buy health insurance. I am concerned that one of every five children in this country is without insurance and the access to the basic care we want and expect for all our children.

What are we going to do to help the many young families, struggling to make ends meet, who do not have and cannot buy health insurance?

We must do something so that the many people who cannot get health coverage because they happen to be afflicted with a disease are able to get health insurance.

We have spent considerable effort to improve access to care and protection from catastrophic illness for our parents and

grandparents. We have increased the availability of Medicaid for poor mothers and their infants and for the elderly. But, this is not enough if we are to address the problem of the uninsured.

In the past we have relied on employer sponsored health insurance for the employed and Medicaid for the poor. But, we have a problem of shrinkage. Private employer sponsored insurance is leaving more and more employees and their dependents without insurance. Medicaid is covering a smaller proportion of the poor.

We must assure that all people in our country have available and affordable health insurance. This goal may sound simple, but attaining it will be a complex process. It will require the participation of the private and public sectors.

There are many problems we must address as we work on the problem of the uninsured.

Who is responsible for sponsoring the health insurance of the uninsured? Who is responsible for the employed? Who is responsible for the unemployed? What should the role of Medicaid be?

If we are concerned about whether people have insurance, should we also care what kind of coverage they receive? Is prenatal care and dependent coverage a priority? Should we care about the quality of the care received?

Since cost of care is a force making health insurance more expensive and even more out of reach for low income people, should we do more to control these health care costs? What can we do?

The solution will require the good intentions and the hard work of everyone.

Today we have a distinguished panel that will, I am sure, be able to give us data and opinions on this problem and these questions.

We also have people here who represent all of the groups that will need to work together to solve this hard, but resolvable problem. If any of one thinks this will be an easy process, they are sorely mistaken. We must all work together.

I look forward to hearing from all of you.

STATEMENT OF SENATOR DONALD W. RIEGLE, JR.
SENATE FINANCE HEALTH SUBCOMMITTEE HEARING ON THE UNINSURED
JULY 25, 1988

Mr. Chairman, I commend you on holding hearings on health care for the uninsured.

I am deeply concerned about the growing number of Americans being denied access to health services. Up to 37 million Americans do not have health insurance in this country. And one-third of uninsured are children, the most vulnerable of our society.

The uninsured are a diverse group spanning all ages, income levels and employment status. Nationally, about two-thirds of the uninsured are employed or their dependents. While 36 percent have family incomes below the poverty level, nearly 20 percent are at 3 times the poverty level or higher.

The adverse consequences of being uninsured are many. The uninsured are less likely to obtain care. They see a physician two-thirds as often as the insured, and spend three-fourths as many days in the hospital. Americans without health insurance have major barriers to obtaining needed medical care. One million Americans annually are denied health care because they cannot pay for it; an additional fourteen million do not even seek care they feel they need because they know that they cannot afford it.

The problem of being uninsured has a particularly dangerous effect on our future generations. Uninsured pregnant women are less likely to seek medical care in the first trimester of pregnancy, reducing the chance for a healthy beginning.

The current coverage of health care needs in this country is grossly inadequate. The combination of private initiatives and public programs in the U.S. leaves many individuals without health insurance. Private insurance, chiefly employment-based, remains the primary source of health coverage for most Americans, however, employers are not required to provide health insurance. Medicare covers health insurance for the aged and disabled; while Medicaid finances services for certain categories of the poor, primarily single mothers with children.

However, Medicaid eligibility guidelines are below poverty levels in many states; so many poor, non-elderly Americans remain uninsured. In recent years, due to fiscal pressures on Federal and State governments, Medicaid has covered fewer poor Americans. In 1976, Medicaid covered 65% of the poor, but covered just 38 percent in 1984. Major gaps exist in coverage for: the unemployed; part-time or part-year workers; dependents of employees; those not able to afford insurance or not eligible for public insurance; and individuals working for employers not able to or willing to provide health insurance.

Patients without insurance do not have a guaranteed source of payment for health services, which may limit access to care. When the uninsured do obtain services, they must pay for their own care or rely on some form of subsidy. In 1986, private payers were charged at least an estimated 10% surcharge on hospital services to help cover the costs of care for patients who cannot pay. Hospitals incurred about $8.4 billion in uncompensated care in 1986 for the delivery of charity care and care to those with limited ability to pay. However, providers and insurers face pressures to cut costs for insured patients, making more difficult the absorption of costs for patients unable to pay.

Congress must address this inequitable system of health care. I first introduced a bill on the uninsured in December of 1982 and have introduced bills on this topic during the last four Congresses. The focus of earlier legislative initiatives was on the unemployed uninsured; in later versions the focus was broadened to include the working uninsured and other individuals who lack access to health care.

Any proposal on the uninsured must provide access to health care for the entire population of uninsured, just as Governor Dukakis' recently passed Massachusetts Health Security Act for the uninsured. Comprehensive coverage is particularly important in Michigan, where about two-thirds of the uninsured are unemployed.

Providers, insurers, and those purchasing health insurance including employers, employees, and the government all subsidize the cost of care for the uninsured. It is in the interest of all parties to address this problem.

I look forward to continuing my work with you Mr. Chairman on developing a comprehensive proposal to address this most pressing problem.

STATEMENT OF SENATOR JOHN D. ROCKEFELLER IV

JULY 25, 1988

Mr. Chairman, I want to thank you for holding this hearing on the uninsured. Your leadership and committment to improving health care for all Americans is obvious. We have important work to do and this hearing sets the stage for that work.

This past year, under Senator Bentsen's leadership, we have held several hearings on children's health issues. One point was repeated time and time again. If children and their families do not have health insurance, they do not receive essential health services. Nationally, 37 million Americans are uninsured. and one-third of these individuals are children.

In my own state of West Virginia, the problem is scary. Entire families are without any form of health insurance coverage. There are 30,000 more uninsured persons in West Virginia today than in 1980. Sixteen percent of all West Virginians are without health insurance. There are 54,000 children in West Virginia who are uninsured even though at least one parent is working. Only 37 percent of West Virginians with incomes below the poverty line are receiving Medicaid benefits.

These statistics demonstrate the complexity of the uninsured problem. This is a problem which affects workers and nonworkers, children and adults, the poor and the not so poor, the sick and the healthy.

We must be innovative and creative as we work to expand current health programs and create new ways to deal with the problem of the uninsured. We must admit to ourselves that there is no easy solution and that it will take tremendous resources and cooperation between the public and the private sectors. A joint commitment between government, both state and federal, and business, both big and small, is needed if we are going to come up with a solution that makes sense and does not unduly burden any certain sector.

Most importantly, we must be compassionate and caring. Too many people are hurting and unless we act soon the problem will continue to grow worse.

STATEMENT OF DR. PETER T. RUANE

Chairman, SBLC Task Force on Mandated Health Benefits

SMALL BUSINESS LEGISLATIVE COUNCIL

Before the

COMMITTEE ON FINANCE

United States Senate

July 25, 1988

My name is Dr. T. Peter Ruane, I am chairman of SBLC's Mandated Benefits Task Force and the Chairman-Elect of the organization. My full time position is President of the National Moving and Storage Association. We appreciate the opportunity to testify before you on this important subject.

The Small Business Legislative Council (SBLC) is a permanent, independent coalition of over ninety trade and professional associations that share a common commitment to the future of small business. Our members represent the interests of over four million small businesses in manufacturing, retailing, distribution, professional and technical services, construction, transportation and agriculture. A list of our members is attached.

I would like to address three aspects of the matter of providing health insurance coverage for the presently uninsured. The first is the data we have collected on current small business health insurance practices, the concerns we have regarding proposals that have been introduced in this Congress, and finally, our thoughts on the future prospects for providing insurance for the uninsured.

It has been generally accepted that there is a pool of some 32 million persons uninsured in this country. Approximately 17 million are non-workers and approximately 3.7 million are laid off or are looking for work. The remainder are uninsured workers. The Office of Advocacy of the U.S. Small Business Administration estimates that 6 million workers uninsured workers are employed by small business. In addition, 1.6 million sole proprietors are uninsured. On the other hand, the "The State of Small Business" June, 1987, prepared by the Office of Advocacy, reports that: "Health care expenditures in 1950 represented only 4.4 percent of Gross National Product;

by 1985, at $425 billion, they accounted for almost 11 percent. The share of gross payroll spent by employers for health benefits increased by as much as 50 percent between 1976 and 1983. In 1986, health care costs averaged 8 percent of payroll, for an employer outlay of $1,460 per employee."

We have conducted surveys of our member associations and appended to this statement are copies of four industry profiles; one in retailing, two in distribution, and one in light manufacturing. The results are not surprising. The smallest firms tend not to provide coverage and these firms are found predominantly in the retail and service sectors. We found costs to range upward to $150 a month per employee or more.

Our data, overall, is consistent with the data included in the 1987 "State of Small Business Report". An entire chapter, "Health Care Coverage and Costs in Small and Large Business," is devoted to this issue in the report. For example, the SBA study indicates that only 32 percent of retailers are likely to offer coverage. Florists' Transworld Delivery Association, the retail association whose study is appended, indicated 35 percent of their members provide insurance. As the SBA study noted, "Small retail firms are, in general, less profitable, less stable, not unionized and have frequent employee turnover--all factors that deter employers from establishing health benefits. Because these firms are labor-intensive, any added payroll costs affect them disproportionately and may be harder to absorb than in a capital intensive larger company." The significance of the data will be discussed in the following section.

As you know there is a proposal before the Senate to require all employers to provide health insurance coverage for all employees. While I cannot say what is the best way to provide coverage for the currently uninsured, I can say, with certainty, S. 1265 is not an acceptable solution.

I have with me over 13,000 petitions. These petitions were signed, and mailed to SBLC, by small business owners from across the country. Among the types of businesses participating were home builders, bus owners, moving companies, grocers, chimney sweeps, tire dealers, brick distributors, florists, petroleum marketers, consulting engineers, independent laboratories, floorcovering retailers, travel agents, sod producers, construction contractors, landscape contractors, helicopter service firms,

printing shops, audio visual firms, refrigerated warehouses, machinery dealers, realtors, retail druggists, parking lot owners, public accountants, tooling and machining shops, specialty advertising firms and wood machinery manufacturers.

The petitions read as follows:

WHEREAS	Employers have traditionally included in their compensation packages health care options for their employees;
WHEREAS	Millions of employees have exercised their rights to choose health care benefits for themselves and their families;
WHEREAS	Legislation (S. 1265/H.R. 2508) has been introduced which would require all employers to provide health care coverage to all employees;
WHEREAS	Nationally mandated health benefits coverage will place an overwhelming burden on small businesses due to increased payroll and administrative costs;
WHEREAS	Controlling costs is one of the most important factors to the viability of small businesses;
WHEREAS	Small businesses will be unable to absorb increased costs and maintain current levels of employment;
THEREFORE	I am opposed to federal legislation mandating all private employers to provide all employees with specific minimum health benefit coverage.

I believe the message is rather clear. Small business will not accept this approach to resolving the uninsured question. As we see it, there are several significant objectives to the approach of this proposal.

First, we believe the legislation is philosophically misguided. The Federal government should not interfere in the relationship between employer and employee. The fact is, in a small business, each employee is an integral part of the overall successful operation of the business. A small business is truly dependent on its employees and flexibility is important in the small employer/employee relationship. For the truly innovative, growing sector of the small business economy-the job creators-skilled labor is an increasingly important consideration. Businesses, however, should be left alone to conduct the "business of doing business."

Second, the proposal is built upon a foundation of unrealistic assumptions. It has been suggested by some that small business owners make a willful choice not to offer health insurance to their employees; their intent

is to maximize profit. In most cases if the employees do not have coverage neither does the owner. The reality is that most small business owners simply cannot afford coverage. The cost of coverage is significant to a firm with only a modest profit and a labor intensive business. If Congress mandates benefits, how will small business pay for these benefits? You cannot mandate profitability. The "State of Small Business Report," to which I referred earlier, indicates business failures increased by 7.4 percent in 1986 and bankruptcies increased by 12.8 percent. It appears implausible to us that businesses, which this bill will most directly affect, are hiding profits that could be allocated to health care coverage.

We do not believe the cost will be anywhere as low as estimates provided by the proponents of S. 1265, or even current actual costs as disclosed by our survey. The bill assumes that legislating absolute demand will lower the cost of coverage. Such an assumption is based on a belief there will be an incentive for suppliers to compete. First, a captive market, by definition, removes some of the incentive to compete. Only vigorous and rigorous antitrust enforcement can prevent the formation of a cartel. Even this assumes, of course, that there is an opportunity for any competition in the market. Under the proposal, the government would certify regional carriers to provide insurance to those employers that cannot secure coverage through conventional means. The proposal, however, also requires that any employer of twenty-five or fewer employees, which does not have coverage on the day this law is enacted, must obtain coverage from a regional carrier. We believe the creation of the regional carrier system and the mandatory participation requirements virtually lock out private sector competition. We understand why the regional carriers concept was proposed--in the hope it would ensure the availability of coverage for those firms not able to purchase the coverage elsewhere and to provide economies of scale to lower costs. We understand why the requirement for mandatory participation in the regional carrier program was proposed--in the hope it would ensure an adequate mix of insured companies. We understand the motivation for the regional carrier and the mandatory requirement, but we do not believe they will achieve these objectives.

While the drafters of this legislation were constructing ways that will theoretically provide coverage at reasonable cost we believe they failed to

recognize the down-side of the equation. What or who is going to ensure that the regional carriers will price their product at a reasonable level? We can easily envision the need for constant Federal supervision of the process--a new bureaucracy. Worse yet, a regional carrier saddled with marginal firms will soon be back to the government for a handout. Long term Federal government financial assistance to these carriers is only around the corner.

There are further fallacies in the regional carrier concept, described by one insurance industry source as follows:

> "Administrative and marketing expenses almost certainly would exceed 13% and claim costs--the level assumed by the preliminary estimate. Regional insurers would continue to incur marketing expenses to increase their share of the small employer market. Although scale economies could lower some expenses for regional insurers, most of the administrative costs in this market are due to the employers' small size and not the insurers' volume. Regional insurers would continue to experience higher costs caused by the nature of small business, such as high employee turnover, and limited in-house benefits administration. Finally, allowing only a few insurers to market coverage in each region could lead to less, rather than more, competitive pricing.
>
> "Adverse selection in the regional pools will lead to higher than expected premiums for small employers. Regardless of size, employers with poor experience would choose pool coverage if their experience-rated premium exceeded the community rate. At the same time, employers in low-cost areas within regions will be able to obtain lower premiums than the regional community rate and remain outside of the pool. The lack of underwriting or waiting periods, combined with the community rate, also would lead to the formation of groups for the sole purpose of obtaining coverage. Indeed, it could encourage the "hiring" of friends and relatives who already are ill and unable to obtain coverage at standard rates to give them access to inexpensive coverage.
>
> "Finally, the estimates do not include adjustments for claims incurred by employees of firms that fail to pay premiums. These unpaid premium costs already lead to higher expenses in the small employer market and requiring marginal firms to purchase health benefits could increase this cost."

It is ironic to us that the bill will discourage those who have worked hardest to provide coverage for employers--associations--from continuing their efforts. Many associations provide or sponsor insurance programs for their members. The programs work because they provide coverage for those very small businesses. If all businesses joining the association that either do not have coverage, or currently have coverage with another carrier, are precluding from joining the association's plan, as it appears they will be under the bill, it is only a matter of time before those association sponsored or operated programs fail.

The data from our survey clearly reveals that for firms currently providing insurance, the mandate proposal will double or triple their costs.

For those firms unable to provide insurance, whatever the cost, a mandate guarantees a crisis in the business. Sometimes, in debates on national legislation, it is an easy thing to discuss billions of dollars as insignificant. Whatever the aggregate cost of mandate legislation, we cannot lose sight of the impact on each individual business. Question thirteen of our survey asked, "How do you (the small business owner) view the mandate proposal?" The responses, which are included in the appended surveys, make for revealing reading. The terms layoffs and wage cuts appear frequently. The small business community will be forced to react in the only way it can to survive, with cutbacks that will hurt the very individuals this legislation hopes to help.

We are not prepared to offer alternatives, but I would like to offer some observations. First, we believe small business' opposition to any type of mandate is inviolate. If somehow a proposal were to surmount that barrier, the bill reported by the Committee on Labor and Human Resources then stumbles at the next hurdle by failing to recognize that a firm must be profitable in order to offer any benefits, regardless of whether it is in the start-up phase or later. Our surveys indicate businesses do offer insurance as soon as it is feasible for them to do so. Sustained profitability is a key to the survival of small business. The third hurdle S. 1265 fails to cross is offering small business flexibility. The regional carrier system leaves small business few alternatives.

Incentives are important to small business. One of the founding principles, ten years ago, of SBLC was that the tax code should provide economic incentives. In 1986, consistent with that view, we took the not very popular position that elimination of the investment tax credit and other incentives would be detrimental to the future growth of small business and we still believe that today.

I raise this bit of history to say we would support tax incentives for businesses to provide insurance, including full deductibility for the self-employed. We believe deductions or credits could be fashioned to encourage small business to seek coverage.

We also believe we need to make insurance coverage more affordable. Some of this can be accomplished through health care cost containment. We note, for example, that you have taken an interest in "patient outcome assessment

research," to assess the benefits of medical procedures in relation to the costs. In crafting a "package" of benefits, to be included in a bill such as S. 1265, perhaps we need to look at whether medical practices are in fact producing a benefit first to the patient, but also to the community.

Simplicity is best. In the quest to close all theoretical loopholes, we believe congressional regulatory schemes have become too elaborate. Whatever happened to common sense? Actuarial equivalents and elaborate formulas give small business owners heartburn. Ironically, many small businesses are forced to make complicated calculations to determine whether a tax provision or environmental rule applies, only to find out it does not apply after the calculations are made.

In conclusion, I would like to take this opportunity to be a forecaster of future events. We, in the small business association community, are beginning to sense a change in the small business owner's perception of the value of being in business for himself. Small business owners are becoming increasingly frustrated with dealing with the micromanagement of their business by government at all levels. Whether it be taxes, environment, health safety or industry specific regulation, the "hassle" factor is on the rise and the entrepreneurial spirit may not have the elasticity we once believed. There may be a point where being in business for oneself is just not worth it. We believe we must come to grips with that before imposing new burdens on small business. The assumption that the employer has a social or economic responsibility has limits. We are not prepared to say today whether we have stepped over that line, but I suspect we will hear much more about this phenomena of frustration and micromanagement in the 101st Congress.

I appreciate the opportunity to discuss our views on the issue of providing health insurance for the uninsured. I will be happy to answer any questions you may have.

/0542
Attachments

STATEMENT OF CARL J. SCHRAMM

PRESIDENT

HEALTH INSURANCE ASSOCIATION OF AMERICA

ON

ACCESS TO HEALTH CARE FOR ALL AMERICANS

I am Carl J. Schramm, President of the Health Insurance Association of America. HIAA is a trade association of 360 commercial insurance carriers who provide approximately 40 percent of the health insurance services in the United States. Approximately 10 percent of our membership's business comes from individuals, 40 percent from employers with fewer than 100 employees, and 50 percent from employers with more than 100 employees. The combined efforts of HIAA's members, the Blues plans and HMOs have succeeded in protecting 180 million Americans. However, we recognize that this is not enough.

Mr. Chairman, our member companies are greatly concerned about those 35 million Americans who do not enjoy the protection of health insurance. Over the last two years, our membership has worked hard to develop creative solutions for extending health care benefits to uninsured groups and individuals. On behalf of HIAA, I am pleased to report a commitment among our companies to work with government in implementing effective approaches for providing coverage to this population.

The task of ensuring that all Americans enjoy the protection of insurance is complex. This complexity is largely a function of the heterogeneity of the uninsured, and the very nature of this group requires a combination of private and public solutions.

One third of the uninsured are poor (with family income below 100% of the federal poverty level); one third are near poor (between 100% and 200% of the poverty level); and one third are non-poor (above 200% of the poverty level).

Eleven percent of the uninsured are the self-employed and their families; 13 percent are half-time employees and their families; and 51 percent are full-time employees and their families.

Finally, uninsured workers are disproportionately employed in certain industries (retail trade and services) and by smaller firms.

All of the above factors make any single solution difficult. As such we see the need to address the special needs of the various subpopulations within the 35 million uninsured with a simultaneous multi-pronged approach. We propose a specific four-point plan which, taken as a whole, provides a comprehensive blueprint to cover the uninsured:

1) The public sector must be responsible for the poor. Accordingly, HIAA proposes the expansion of Medicaid to all those below the federal poverty level, regardless of family structure or employment status.

Ultimately, we would like to see the following changes made in the Medicaid eligibility standards:

- o Eliminate categorical restrictions on eligibility for Medicaid and Medicaid spend-down so that Medicaid is made available to anyone below the federal poverty level;

- o Allow states to uncouple the income eligibility standards for welfare payments from eligibility for Medicaid;

- o Eliminate eligibility restrictions (such as the limit on hours worked) for those individuals and families who may be employed, but still remain below the eligibility income standard;

- o Provide opportunities for other low income individuals to participate in Medicaid by requiring all states to have a medically needy program and by allowing low income individuals to buy into Medicaid, preferably through an income-related premium.

The members of this Subcommittee know, far better than I, the intricacies of Medicaid eligibility, its shortcomings and the funding crisis that preserves them. HIAA knows that this Committee has helped lead the fight and succeeded in enacting incremental improvements in Medicaid year after year.

This committee has before it several bills which would be a reasonable first step along the road to assuring everyone equal availability of care.

S. 2122, The Medicaid Infant Mortality Amendments of 1988 sponsored by Senator Bradley and co-sponsored by seven other members of this committee from both sides of the aisle deserves early consideration and has our full support. Unless we are able to give all poor women and their young children proper care, the uninsured gap will remain. More importantly any hope we have of closing the infant mortality gap will be seriously jeopardized. I believe there are other bills before you, which also deserve consideration, sponsored by Senators Durenberger and Chafee which also address these issues in whole or part.

2) Insurers should be allowed to offer more affordable coverage, including prototype plans. ERISA preemption of state mandated benefits should be extended to insured employee plans as well as to self-insured plans so that insurers can design less expensive benefit packages for small businesses.

HIAA will support statutory changes to enable insurers to make lower cost prototype plans available. All prototypes would be actuarially equivalent in value and include basic inpatient and outpatient physician, hospital and diagnostic services. Additional services, such as dental and mental health, would be offered in some of the prototypes in exchange for higher copayments. In all prototypes, managed care features would be permitted.

3) Coverage must be made available to all Americans. This is true, even for those whom insurers might normally decline due to existing high cost medical or occupational conditions. There are two components to consider here: uninsurable individuals and uninsurable employer groups.

HIAA seeks Federal legislation encouraging all states to enact a qualified state pool for medically uninsurable individuals. Such pools have already been enacted in 15 states. Each pool should be a nonprofit corporation with coverage available only to uninsurable individuals who are not eligible for coverage by employer plans, Medicare or Medicaid. Pool losses should be financed by state general revenues or any other broad based funding mechanism that does not assign losses disproportionately to any individual or corporate entity. In the absence of action by a state, the Secretary of the Department of Health and Human Services (HHS) should establish a qualified pool in that state, in which case losses, if any, would be paid from federal health funds the Secretary would otherwise spend in the state.

To ensure access to group coverage for all employees, a nonprofit organization should be established to reinsure uninsurable employer groups. Employers would access the reinsurance organization indirectly via insurers, or directly if unable to purchase coverage through an insurer. Losses incurred by the reinsurance organization could be financed entirely by the private sector if shared equitably among competitors in the small group market and all larger health plans whether insured or self-insured.

4) Small businesses must be given a greater incentive to provide coverage for their employees. Self-employed individuals should get a 100 percent deduction for their health insurance protection, as long as they provide equal coverage to their employees.

It is our belief that this four-point plan provides a blueprint for a truly comprehensive approach to the problem of uninsured citizens. The plan stresses the sharing of responsibility between government and the private sector. It calls on the private sector to provide for new private products and practices and government to reinforce its 1965 commitment to poor citizens through the Medicaid program.

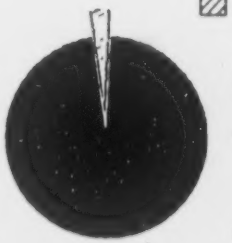
We believe it unwise and unnecessary to propose a single solution, namely employer mandated insurance with a system of untried regional risk pools. In fact, the costs of the comprehensive benefits proposed under legislation such as S. 1265 actually might hinder marginal employers in their search for insurance.

In closing, I would recall that the private insurance system is built on the principle of risk selection. It is a highly competitive industry, composed of over 600 companies,

committed to providing insurance to ever larger numbers of Americans. Using high risk pools and reinsurance we could underwrite anyone regardless of their health status. But we cannot insure anyone regardless of their ability to pay. Mandating coverage will not change this fundamental reality, nor make coverage affordable. Health insurance is expensive because health care is expensive. There are no magic bullets or free lunches. But we can work together to develop and implement effective solutions.

Thank you.

HOW THE HIAA PROPOSAL WOULD PROVIDE COVERAGE FOR THE 35 MILLION UNINSURED

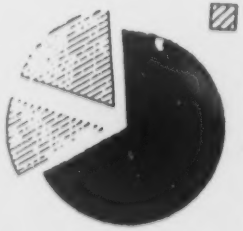


COVERAGE FOR UNINSURABLES

- 3%, or one million, of the uninsured are uninsurable individuals.
- Under the HIAA proposal, states would create pools to cover uninsurables not eligible for other types of coverage.
- Financing is private and public.

COVERAGE FOR THE SELF-EMPLOYED

- 11%, or 4 million, of the uninsured are self-employed and dependents.
- Under the HIAA proposal, the self-employed would be extended a full 100% tax deduction for health benefits.
- Financing is private.



MEDICAID EXPANSION

- 32%, or 11 million, of the uninsured are below the poverty level.
- Under the HIAA proposal, all persons below the federal poverty level would be covered by Medicaid.
- Financing is public.

EMPLOYER COVERAGE

- 64%, or 22 million, of the uninsured are employees and dependents.
- The HIAA proposal would provide access to low-cost coverage for all employees.
- Financing is private.

Labor Market Responses Under Mandated Health Insurance

The difficulty of predicting the labor market effects of an employer mandate is pointed up by the diversity of opinion among economists. Ideally, not only must one make certain assumptions about the microeconomics of how the firm and its employees will respond to new incentives, but also must make assumptions about the behavior of the overall economy and even that of other countries. Unfortionately, we have far from perfected either the science of micro or macroeconomics to the point in which we can accurately predict the effects of changing the cost of fringe benefits on employer labor force decisions.

In theory, a firm may respond to a mandate by doing any number of the following: (1) raising product prices to pass costs onto the consumer, (2) shifting to less costly forms of production by becoming more capital intensive (an option open to fewer and fewer employers as the economy becomes more service based), (3) increasing employee efficiency through organizational, management or other changes, (4) lowering employee compensation in other areas (wages, fringe benefits, hours worked) and (5) coincidental to or as a result of the above, workers may be layed off.

At the macro level, growth in overall labor productivity (which is largely linked to the educational level of the labor force), overall economic growth, international competition, and the country's position in the business cycle will all influence how firms in the aggregate will react to a mandate.

Most of the research to date has focused upon the disemployment effects of a minimum wage increase. This may be

explained by the close to home nature of job loss as well as the extreme difficulty of measuring and studying other less easily quantifiable factors such as management changes, etc.

Macroeconomic Forecasting Models

In recent months, two macroeconomic forecasting models [Wharton and Data Research Institutue (DRI)] have been used to simulate the effect of the Kennedy health insurance mandate. The Kennedy staff and Karen Davis of Johns Hopkins on numerous occasions have cited small labor market effects from such models. For example, the DRI model predicts a loss of 100,000 jobs over three year period under the Kennedy mandate. Wharton predicts no job loss after a two year period.

Both the Warton and DRI models are designed to simulate very broad changes in the economy such as the effects of government fiscal or monetary policy on inflation, interest rates, Gross National Product, etc. First, I question even their ability to do this with accuracy. One can find very large variance between predictions of the 20 or so well known macroeconomic models, as well as very large differences between what was predicted and what actually happened historically (see the Blue Chip Economic Consensus Reports). Second, as a former labor economist, I can tell you that these models are not well suited to simulate the microeconomic effects of a mandate. In these models, elements such as wages are meant to be used as output variables not as critical input variables. A related concern is that the models are not "disaggregated" enough to accurately predict the lopsided and fairly severe economic effects on certain industries and workers, on the one hand, and the very small or negligible impact on others. Finally, these models ignore so called "second order effects" such as shifts

to lower paying or nonmandated industries, the proliferation of more part-time workers and independent contractors, etc. Consequently, I do not find it surprising that these models have produced negligible economic effects. Using existing empirical evidence on the effects of the minimum wage is perhaps a sounder way to investigate this issue.

Empirical Evidence on the Minimum Wage

The existing empirical work has focused largely upon the effects of the minimum wage on teenage employment. This research shows that a 10 percent increase in the minimum wage reduces teenage employment by 1 to 3 percent. Study on the effect of the minimum wage on adults' employment is less definitive but shows effects closer to the lower end of the teenage range. It seems clear that the response to a minimum wage increase or a mandate would vary by industry. One study estimated a reduction in retail trade employment of 5 percent for every 5 percent increase in the minimum wage. Other research found a 1 percent reduction in employment among the service sector for every 10 percent increase in wages. Similar results were found for manufacturing.*

In the context of the Kennedy debate, most recently Ken Thorpe of Harvard concluded that an increase of 10 percent in wages would lead to a one to three percent reduction in employment. The Kennedy mandate would amount to roughly a 20 to 25 percent increase in in compensation for those at the minimum wage. Thorpe maintains that this would generate a loss of between 180,000 and 360,000 jobs. For the record, I would rather stay out of the numbers game on this issue. However, I find these estimates within reason for a number of reasons, including: (1) uninsured workers' concentration in low wage

jobs (75% earn less than $10,000/yr), (2) the slightly younger age of the uninsured population (suggesting a tendency towards teenage employment patterns), (3) a concentration of uninsured in the retail trade sector and among small firms, (4) failure of real wages to grow measurably over the last ten years, (5) the fairly high likelihood of an economic downturn in the near future.

Additionally, if one added the proposed minimum wage increase on top of the health insurance mandate, job loss of one-half a million or more certainly seems a possibility.

Potential Employment Offsets in the Health Care Sector

I find the claim by Karen Davis that health sector job growth would at least offset the decline of employment in other industries neither terribly convincing nor relieving. The health care sector has historically sustained very large annual increases and fluctuations in costs without corresponding swings in personnel (health care employment has grown at a fairly stable rate in recent years, albeit a very fast one). This is partly because of the fixed nature of health manpower due to the professional education process. Ten to twelve billion in new health dollars resulting from the Kennedy mandate represents less than two percent of health care expenditures, a much smaller swing than has taken place in many years. But, for rough illustration sake, let us say that employment in the health related sectors could respond quickly and considerably. In fact let us go to the extreme and assume that health related employment could grow in equal proportion to that of the increase in health care spending resulting from the mandate (just under two percent). Even in this extreme and highly unrealistic case, only 125,000 or so new jobs would be created.

But numbers aside, I return to the statement that I made before your Committee. The health care sector is consuming an ever growing share of our nation's resources. Today health care represents roughly 11 percent of the Gross National Product, and some predict that by the year 2000 this figure will be 15 percent. It is my feeling that the health care sector is the last place that we want to be generating new jobs. I, therefore, find it hard to declare a victory over the potential employment increases that might result from an employer mandate. We need to be focusing our energies on increasing employment in other areas of the economy.

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* For a review of the literature see Eccles, Mary and Richard Freeman, "What! Another Minimum Wage Study?" American Economic Review, May 1982.

COMMUNICATIONS

AMERICAN CHIROPRACTIC ASSOCIATION

August 17, 1988

Honorable George Mitchell
Chairman
Subcommittee on Health
Senate Committee on Finance
205 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Mr. Chairman:

We would appreciate inclusion of this letter in the record resulting from the July 25, 1988 hearing on access to affordable health care.

Mr. Chairman, the laws of forty-five states currently protect the right of a health-care consumer to choose the type of physician he or she desires to render services covered by his or her health benefit plan.

It only makes logical sense that this same protection be afforded to the presently uninsured once they are brought under any form of health insurance.

But such will not be the case if those state laws are federally preempted as is contemplated by most pending legislation.

There is a generally-held belief that legislation providing health insurance to those presently uninsured must at the same time preempt the many existing state laws enacted over the last quarter of a century which protect the interests of current health-care consumers. We do not subscribe to that belief; the right every health care consumer should have to choose the state-licensed health-care practitioner he or she wishes to discharge benefit-plan-covered services is not a right to be nonchalantly eliminated. The preemption of state laws regulating the content of health insurance may be undertaken in the name of national uniformity, but without a uniform and commensurate federal law to replace those state laws -- and there is no such federal law pertaining to individual, private health benefit plans -- the freedom of choice protections afforded by those state laws are lost forever.

Access to affordable health care cannot be considered adequately provided until every newly-insured individual has access to a full range of health care providers. Any legislation that is silent on this issue or which fails to adequately define the types of health-care providers a consumer may see to obtain covered benefits (and whose health-care services are fully reimbursable under the plan in question) fails to provide complete access to health-care and certainly lessens the impact of competition on overall health care costs. The dual purpose of access to affordable health care is then significantly compromised.

As your Committee proceeds to draft legislation providing affordable care to the presently uninsured, we urgently request that it refrain from preemption of state laws regulating the content of health benefit plans. In the event such preemption must be made, however, then it is imperative that newly-covered health-care consumers be allowed reimbursable access to chiropractors to the same extent (within the scope of a chiropractor's license) that they may avail themselves of the services of other state-licensed practitioners recognized by the legislation for the treatment of any health condition covered by the plan. This can be accomplished by including doctors of chiropractic in any definition of "physician" under such draft legislation, and by providing a broad, federal freedom-of-choice of health-care practitioner provision, assuring a patient the right to seek authorized and reimbursable care from any state-licensed health care practitioner who has the authority to render it.

If coverage of "physician services" were to be left undefined, it would in our opinion, assure exclusion of patient reimbursement for the services of chiropractors and many other state-licensed practitioners. That is not in the best clinical or economic best interest of those you are seeking to cover.

The American Chiropractic Association looks forward to working with the Committee in drafting legislation that not only provides high quality and affordable health-care protection to millions of Americans presently without such protection, but legislation which also recognizes that there are competent, compassionate, and affordable health-care providers other than just physicians who are defined as M.D.'s and/or D.O.'s.

Sincerely,

Ronald L. Harris, D.C.

cc: Dr. Robert P. Lynch, Jr., ACA Delegate, State of Maine
W. Randall Rawson, ACA Director of Governmental Relations

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

Re: Providing Adequate Health Insurance Coverage for the Uninsured and Underinsured

July 29, 1988

The American Medical Association takes this opportunity to express its views concerning the important issue of providing adequate health insurance coverage for the many Americans who are uninsured or underinsured. We request that this statement be included in the record of the July 25 hearing of the Health Subcommittee concerning providing health insurance for the uninsured and underinsured.

Scope of the Problem

Lack of adequate health insurance coverage is a serious problem in this country. Although the exact number of persons who lack health insurance coverage is not known, a recent study by the Congressional Research Service (CRS) estimates that about 37 million Americans had no coverage at any time during 1986. The CRS found that the percentage of persons lacking health insurance has increased from 14.6% in 1979 to 17.5% in 1986. More than half of the uninsured were employed during at least part of the year. About 30% of the uninsured had incomes below the federal poverty level. Another 30% had incomes under 200% of the poverty level.

It is estimated that about 1 million of the uninsured are persons who are considered to be "medically uninsurable." These persons are either

unable to obtain health insurance coverage or can obtain such coverage only at extremely high rates because of poor health status, previous medical history, or employment in a medically hazardous occupation.

In addition to the uninsured, millions of other Americans lack adequate health insurance coverage. Thus, while these persons have health insurance, they may still be financially vulnerable and may lack access to necessary health care services.

The problem of the uninsured is heightened by the change to a "prudent buyer" mentality by both public and private sector purchasers of health care. An unexpected result of this redirection has been that cost-shifting, the historically accepted means to finance care for the uninsured, has become more difficult, if not impossible.

Studies already indicate that the uninsured have fewer physician visits, spend fewer days in the hospital, and are less likely to seek medical care when ill. We are concerned that with the U.S. health care system becoming more competitive and cost-conscious, the uninsured will experience increased difficulty in finding access to necessary health care services.

AMA Proposals

While we encourage and commend the impressive voluntary efforts of the many individual physicians across the country who provide charity care, the AMA recognizes that the magnitude of the problem of the uninsured and underinsured makes government action necessary. Because no single approach would adequately address the health care needs of all of the uninsured and underinsured, the AMA has developed a number of state and federal legislative proposals for extending adequate health insurance coverage to unprotected individuals.

State Risk Pools

The AMA strongly supports the enactment of state risk pool legislation that would provide coverage for the uninsured, the underinsured and the medically uninsurable. (Fifteen states already have enacted risk pool legislation to create health associations that sell policies to high-risk, uninsurable individuals. These pools use a variety of mechanisms to make coverage available while spreading the cost of covering the medically uninsurable over a large population.) In our view, persons with incomes above the poverty level who are unable to afford individual health insurance policies but who could buy coverage, if offered, at group rates should be eligible. The pools should provide a specified level of adequate benefits and should set premiums at not less than 110% or more than 125% of the average premium for comparable group coverage by insurers in the state. States should provide publicly funded vouchers on a sliding scale to help those persons with incomes between 100% and 150% of the poverty level pay the premium for pool coverage. About 5 million people would qualify for such voucher assistance. Persons with incomes between 150% and 200% of the poverty level should also be eligible to purchase pool coverage, but at their own expense.

It is likely that the costs of risk pool coverage would not be met totally through enrollee premiums. In that event, risk pool costs in excess of premium income should be spread as widely as possible. The AMA believes strongly that all health care underwriting entities in the state, including commercial carriers, non-profit medical service plans, health maintenance organizations, and self-insured plans, should be required to participate in the risk pool. By having all carriers participate, the pool would be assured a financial base sufficient to support the program and to achieve a fair sharing of the risks. Unfortunately, states currently are prohibited by the Employee Retirement

Income Security Act (ERISA) from requiring that self-funded employee benefit plans participate in state risk pools. This prohibition creates strong barriers to effective operation of state risk pools since self-insured plans write over half of the employee group health insurance business.

In order to achieve broad participation in state risk pools, the AMA has developed draft federal legislation that would amend ERISA to require states to regulate self-insured plans in the same manner that other health insurance plans are regulated. Self-insured plans would thus have to participate in state risk pools. The AMA has also developed draft federal legislation that would allow employers to deduct their health insurance premiums only if they purchase group health insurance coverage from an entity that participates in the risk pools. A copy of each of these draft bills is attached to our statement. We urge that these bills be given careful consideration.

The AMA supports the use of state tax revenues as an alternative to assessing the carriers participating in the pools for any excess pool costs over premium income. Using state tax revenues would spread the pool costs over all state taxpayers rather than over only the policyholders of participating carriers.

Establishment of State Indigent Care Funds

We support the establishment of state indigent care funds that would pay providers in proportion to the amount of uncompensated care they render. These funds would be financed from general revenues and would reimburse uncompensated care costs for those who remain uncovered under either state risk pools or through an expanded Medicaid program.

Medicaid Reform

The AMA believes strongly that federal and state governments have a legitimate role in assuring access to medical care for persons with incomes below the poverty level. It is well documented, however, that the current structure for providing most of the health care services for this population group, the Medicaid program, is fraught with problems and major reforms are needed.

We have just completed a thorough study of the Medicaid program. The report on the study was recently approved by the AMA House of Delegates and is attached to this statement. It finds the following major flaws with the Medicaid program:

- o no coverage for about 60% of the people with incomes below the poverty level. (About 20 million persons with income below the poverty level are not currently covered by Medicaid because they do not meet categorical or income eligibility requirements);
- o wide variation in eligibility criteria from state to state;
- o wide variation in benefits from state to state, with underfunding of medical services to finance less beneficial services; and
- o grossly inadequate physician and hospital reimbursement levels which serve to restrict access to care.

The AMA report concludes that reform of the Medicaid program should be based on the following principles:

- o the creation of a basic national standard of uniform eligibility for all persons below the federal poverty level (adjusted by state per capita income factors);
- o the creation of basic national standards of uniform minimum adequate benefits;
- o the elimination of the existing categorical eligibility requirements; and
- o the creation of adequate physician and hospital reimbursement levels to assure broad access to care.

The AMA is aware that implementation of the above principles would result in a significant expansion in the number of Medicaid beneficiaries

and in the amount of state and federal spending under the Medicaid program. In our view, however, no other solution would adequately address the health care needs of the uninsured with incomes below the poverty level.

Temporary Extension of Coverage

Workers who are laid-off should have the opportunity to maintain employment-based health insurance for at least several months after their termination. The AMA supports legislation that would require employers to offer to continue health coverage for laid-off workers and their dependents for up to four months after the lay-off, with the employer and ex-employee continuing to pay the same percentage of the premium they had paid before the lay-off.

Enactment of this legislation would encourage laid-off employees to continue their health insurance coverage in their former employer's group health plan because they would not have to pay the full premium. In addition, we support the provisions in P.L. 99-272 that require employers to make group health insurance available for terminated workers at the worker's sole expense for an additional 18 months.

Open Enrollment Period

The AMA supports legislation that would mandate that an employer's group health plan must provide an open enrollment period of at least 60 days for spouses of unemployed workers. In some two-income families, only one spouse may be enrolled in a group health plan. Currently, if that spouse becomes unemployed, the whole family would be without health insurance coverage. Enactment of mandated open enrollment legislation would appropriately address this situation.

Deduction for Self-Employed Individuals

Currently, self-employed owners of unincorporated businesses can deduct as a business expense only 25% of the cost of premiums for their own health coverage. Self-employed owners of incorporated businesses can take a full business deduction for their own health insurance premiums if they provide coverage for their employees.

The AMA supports legislation that would allow all self-employed individuals to take a 100% business deduction for group health plan contributions paid for their own health coverage if they provide adequate health insurance coverage for their other employees. Permitting self-employed individuals to take a full business deduction for their own group health plan contributions would encourage them to offer health insurance coverage to their employees and would create parity with incorporated businesses.

Encouraging Formation of Multiple Employer Trusts

The AMA believes the federal government should encourage the increased formation of Multiple Employer Trusts (METs). METs allow small employers to combine their buying power and spread their risks over a larger employee group, and their encouragement should result in more small employers being able to afford to either directly offer or to purchase adequate health insurance coverage for their employees. The AMA recognizes that those states currently not regulating the fiscal solvency of METs would need to enact appropriate legislation. In addition, a mechanism would be needed to ensure that METs purchase or provide adequate benefits. The AMA has developed draft legislation that would provide such a mechanism by amending the federal tax code to make the provision of adequate benefits a condition for an employer to deduct the

cost of group health insurance premiums as a business expense. A copy of this draft legislation is attached to our testimony.

Studies of Tax-Supported Subsidies to Small Employers

The AMA believes that feasibility studies should be conducted concerning the effect of providing tax-supported subsidies to small or low-wage employers to assist them in purchasing adequate health coverage for their employees. These subsidies could make adequate health insurance accessible to many workers who are currently uninsured.

Conclusion

The AMA is very concerned about the fact that millions of Americans lack adequate health insurance coverage. The severity of the problem of the uninsured and underinsured makes further federal and state government action necessary. We have developed a number of proposals for extending adequate health insurance protection to the uninsured and the underinsured. Our proposals involve providing coverage through the private sector for the uninsured and underinsured with incomes above the poverty level and through an expansion of Medicaid for the uninsured with incomes below the poverty level. We urge the Committee to give careful consideration to the AMA's proposals.

REPORT OF THE BOARD OF TRUSTEES

Report: UU
(A-88)

Subject: Medicaid - Towards Reforming the Program

Presented by: Alan R. Nelson, M.D., Chairman

Referred to: Reference Committee A
(Clarence H. Denser, Jr., M.D., Chairman)

Background and Goals

At the 1987 Annual Meeting, Recommendation 153 of the HPA was referred to the Board of Trustees. This recommendation states:

> Medicaid should be revised to establish national standards that result in uniform eligibility, benefits and adequate payment mechanisms for services across jurisdictions.

The Board of Trustees requested the Councils on Medical Service and Legislation to study this issue and work with the Board in development of this report.

The Councils and the Board have extensively analyzed the various approaches for improving Medicaid coverage for those in need. This report presents background information and policy recommendations developed by the Councils regarding the Medicaid program. During their deliberations, the Councils also examined the broader picture of the "uninsured." The AMA has established policy favoring the enactment of state risk pools for the medically uninsurable and the premium indigent, including voucher assistance for lower-income segments of the latter group. A summary of this policy is provided in CMS Report A, also before the House of Delegates at this meeting. The Councils and Board will continue to study approaches for providing health expense protection for the uninsured above the poverty level and will report new developments to the House. This current report addresses the portion of the uninsured population below poverty.

In developing this report, the Councils have utilized expert actuarial analysis which recognized the federal government's legitimate role in assuring needed medical care benefits for the needy. The report recognizes that states may wish to cover additional populations and benefits at their sole expense.

Our study has confirmed the severe inequities in the current Medicaid program from one state to the next. It is a program in desperate need of reform. The Councils and Board believe that reforms of the Medicaid program should be based on the following basic principles:

(1) the creation of basic national standards of uniform eligibility for all persons below poverty level income (adjusted by state per capita income factors);

(2) the creation of basic national standards of uniform minimum adequate benefits;

(3) the elimination of the existing categorical eligibility requirements; and

(4) the creation of adequate payment levels to assure broad access to care.

These principles are consistent with HPA Recommendation 153. The Board and Councils are aware that implementation of the above principles will result in a significant expansion of the number of beneficiaries and amount of spending under the Medicaid program. There is, however, no other solution which adequately addresses the needs of currently unprotected persons with incomes below the poverty level. Set out in this report is information based on data provided to the AMA by its consulting actuaries on this project.

Current Medicaid Program

The major flaws in the existing Medicaid program can be summarized as follows:

- no coverage for about 60% of the people with incomes below the poverty level;
- wide variation in eligibility criteria from state to state;
- wide variation in benefits from state to state, with underfunding of medical services to finance less beneficial services;
- grossly inadequate payment levels which restrict access; and
- allocation of available resources to long term care for the elderly at the expense of acute care services for the needy.

Several examples from a 1987 General Accounting Office study entitled "Medicaid - Interstate Variations in Benefits and Expenditures" indicate the significance of the above noted flaws in the existing Medicaid program:

- nine states have fewer than 25 Medicaid recipients for every 100 residents below the federal poverty level, with ranges going from 17/100 to 104/100;
- in 1986, to be eligible for Medicaid under AFDC (Aid to Families with Dependent Children) criteria, a family of three could have a maximum annual income ranging from $1,416 in Alabama to $8,800 in Alaska;
- in 1986, to be eligible for Medicaid under SSI (Supplemental Security Income), an individual could have maximum income ranging from $4,032 in 22 states to $7,260 in Alaska;
- wide variations in benefits (e.g., 10 states place limits on the number of hospital days of care allowed, 11 states place limits on the number of physician office visits allowed per year); and
- wide variations in payment levels (e.g., 1985 hospital payments ranged from an average of $160/day in Nebraska to $533/day in the District of Columbia; payments for a physician's brief office exam ranged from $6.00 in New Hampshire to $28.41 in Alaska).

Dimensions of Uninsured Poor

Based on various sources, including HCFA information and extensive information provided by the actuarial firm of Gordon R. Trapnell Consulting Actuaries, Ltd., the consulting firm retained by the AMA for the Medicaid project, data indicate that:

- there are about 20 million persons with below poverty annual income who are not currently covered by Medicaid because they do not meet categorical or income eligibility requirements; and

- there are about an additional 7 million persons who are in poverty for some portion of the year (but not on an annual basis) and are not currently covered by the Medicaid program.

Thus, reforming the Medicaid program to provide acute care coverage for all persons below 100% of the poverty level, while maintaining existing eligibility requirements for long-term care coverage, would have the following impact:

- increase total Medicaid spending from a projected $52 billion in 1988 under current law to $76 billion in that year (acute care spending would constitute $32 billion and $56 billion respectively); and

- increase the number of persons eligible for Medicaid acute care benefits from a projected 19 million persons in 1988 to a projected 46 million persons in that year.

These actuarial calculations are based on an improved set of uniform acute care Medicaid benefits (described later in this report). The total number of projected recipients reflects all persons who are eligible for any portion of the year. The calculations have also been prepared on the basis that no person currently eligible for Medicaid would be dropped from the program because of the proposed reforms.

Consideration was given to recommending eligibility for all persons below 50% or 75% of the poverty level. At the 50% level, spending would increase to $61.4 billion (rather than $76 billion at 100% poverty level), and the number of eligibles would increase to 36 million (rather than 46 million at 100% poverty level); at the 75% poverty level spending would increase to $67.3 billion (rather than $76 billion at 100% poverty level), and the number of eligibles would increase to 41 million (rather than 46 million at the 100% poverty level).

It can be readily seen that to limit eligibility at either 50% or 75% of poverty level would not present dramatic savings compared to the 100% poverty eligibility level. It would be undesirable from the standpoint of creating equity and uniformity in the program to cut off eligibility at a level less than 100% of poverty. From the viewpoint of protecting those in need, supporting eligibility at the 100% poverty level rather than the 50% or 75% of poverty level presents a much more desirable position.

A comparison of the estimated total Medicaid spending and the number of eligible persons covered for acute care in 1988 under the current law and for the expanded and modified program is included in Attachment A for each state and the U.S. as a whole.

The Board and the Councils are fully aware of the political difficulty in bringing about an expansion in Medicaid spending and

caseload of this magnitude. The above expansions of eligibility and actuarial projections are based upon the following reforms to the program:

- enhanced eligibility would apply to acute care services only; existing eligibility criteria as well as benefits and payment levels for long-term care would not change from the current Medicaid program;

- a uniform acute care benefit package (described later in this report) would be required of all state Medicaid programs;

- payment rates for physicians at Medicare levels would be required in order to increase access to care; and

- determination of state poverty level income in the actuarial calculations has been adjusted by the following factor:

$$\frac{\text{state per capita income}}{\text{national per capita income}} \times \text{federal poverty level} = \text{state level}$$

Uniform Financial Eligibility Formula

Use of the state cost-of-living modifier as described above is essential to assuring that Medicaid eligibility reflects the economic realities in the various states. At the same time, using one national formula by which eligibility will be determined in the various states will eliminate state discretion in setting the economic level of eligibility. This will avoid perpetuating the widespread inequities existing across state boundaries today.

Table 1 illustrates the effect of using this cost-of-living modifier by comparing the total cost of Medicaid in selected states under a 100% of poverty standard which is uniform nation-wide versus a standard adjusted by that state's cost-of-living modifier.

Table 1: ESTIMATED TOTAL CARE MEDICAID SPENDING IN FY1988 UNDER UNIFORM VS. STATE-ADJUSTED 100% OF POVERTY ELIGIBILITY LEVELS: SELECTED STATES
(Millions of Dollars)

	Uniform Level	State-Adjusted Level
Alabama	$944	$847
California	$7559	$7992
New York	$12274	$13312
Tennessee	$1540	$1370
W. Virginia	$365	$313

As shown in this table, less affluent states such as Alabama, Tennessee, and West Virginia will experience less of a spending increase under a cost-of-living-adjusted eligibility level, while more affluent states such as California and New York will spend more under such an adjusted eligibility level.

Uniform Benefits

The AMA proposed uniform Medicaid benefit package would extend the current federally mandated basic benefits requirements to cover all medically necessary physician and hospital services. Specifically, the benefit package would include:

Inpatient hospital, Outpatient hospital, and Emergency hospital services; Rural health clinic and other laboratory and x-ray services; Home health services; Early and periodic screening, diagnosis, and treatment for individuals under 21; Family planning; Physicians services; Prescription drugs; and Rehabilitative services. (NOTE: This AMA uniform benefit package consists of the presently required services plus prescription drugs, rehabilitative services, and emergency services, all without limits as to days or number of services.)

States may include additional services solely at their own expense.

Adequate Program Payment Levels

This study has confirmed that unrealistically low reimbursement levels reduce access of Medicaid beneficiaries to needed medical care. The actuarial projections herein are based on Medicare reimbursement rates. Such rates, while inadequate in many cases, would be a clear improvement over the current situation. Such improved payment levels, combined with uniform eligibility and improved benefits, will clearly provide increased access to needed health care. Assuming benefits are extended to all persons below the 100% poverty level, the improved acute care medical benefits and payment levels suggested herein would cost about $300 million less than the current scope of acute care benefits at current payment rates for the same number of people, because a number of currently optional acute care services are deleted under the proposal.

Policy Recommendations

The Board and the Councils recognize that there will be many proposals for modification of the Medicaid program. For example, HPA, through its implementation committees, is currently developing suggestions for changes in eligibility and benefits. The Board and Councils will monitor all proposals for changes and keep the House advised of developments. At this time, the Board and Councils recommend that the Association state its goal of providing greater equity in the program through adoption of the following principles:

(1) the creation of basic national standards of uniform eligibility for all persons below poverty level income (adjusted by state per capita income factors);

(2) the creation of basic national standards of uniform minimum adequate benefits;

(3) the elimination of the existing categorical requirements;

(4) the creation of adequate payment levels to assure broad access to care; and

(5) the adoption of HPA Recommendation 153.

Conclusion

The Board and Councils believe that the expansion of the Medicaid program as outlined in this report will address the needs of the uninsured with incomes below poverty. Further efforts to implement the Association's risk pool policy for those uninsured above poverty, as well as further study of additional ways to assist that group will continue. The Councils and the Board are currently studying potential reforms in the long-term care provisions of the Medicaid

program as part of their overall study of ways to improve both public and private long-term financing mechanisms for individuals at all economic levels.

It is well recognized that the societal costs in addressing the needs of the uninsured are large. The costs of leaving the problem unresolved, however, are and will continue to be even larger.

ATTACHMENT A

Estimated 1988 Total Medicaid Spending and Number of Persons Eligible for Acute Care Under Present Law and Under a 100% Poverty Standard

	Thousands of Eligibles		Millions of Dollars	
	Present Law	100% Poverty*	Present Law	100% Poverty*
TOTAL U.S.	19 million	46 million	52442	76281**
State				
AK	28	93	91	143
AL	339	882	602	847
AR	173	445	483	661
AZ	132	495	199	465
CA	3155	6788	5724	7992
CO	149	413	407	663
CT	180	318	722	934
DC	90	232	358	638
DE	40	107	99	154
FL	547	1595	1235	1849
GA	467	1239	907	1393
HI	94	243	212	370
IA	192	572	505	861
ID	31	112	112	172
IL	1126	2645	2632	3742
IN	251	774	1028	1685
KS	143	384	330	451
KY	382	1188	734	1187
LA	429	1061	1044	1531
MA	475	988	2169	2839
MD	326	830	900	1555
ME	112	278	319	455
MI	1084	2134	2238	3396
MN	289	757	1327	1808
MO	306	921	808	1224
MS	322	845	468	691
MT	44	145	132	251

*Increased number of eligibles and increased dollar amounts due totally to acute care services; no changes in long term care eligibility, benefits or payment levels. Total dollar amounts include costs for both acute and long-term care.

**The uniform AMA suggested benefit package at Medicare payment rates would cost about $300 million less than providing present widely varying benefits under present law to all persons below 100% of poverty.

State	Thousands of Eligibles		Millions of Dollars	
	Present Law	100% Poverty*	Present Law	100% Poverty*
NC	336	953	850	1271
ND	37	121	173	275
NE	91	258	235	377
NH	31	93	154	223
NJ	529	1162	1470	2215
NM	100	307	241	397
NV	25	88	99	175
NY	2021	4129	10123	13312
OH	885	2009	2474	3735
OK	190	499	519	655
OR	125	411	356	626
PA	918	2137	2410	3312
RI	82	168	344	417
SC	247	634	467	706
SD	36	123	139	195
TN	344	1002	870	1370
TX	764	2369	2205	3825
UT	74	245	184	334
VA	311	896	797	1293
VT	45	112	113	157
WA	230	716	788	1189
WI	452	965	1361	1747
WV	175	410	240	313
WY	16	63	45	205

STATEMENT OF DEBORAH J. CHOLLET, Ph.D

EMPLOYEE BENEFIT RESEARCH INSTITUTE

Uninsured in the United States: The Nonelderly Population Without Health Insurance

In 1986, nearly 18 percent of the civilian population under age 65 reported no health insurance coverage from any source.[1] These people totaled 37 million in number. The proportion of the population reporting no health insurance in 1986 was approximately the same as that without health insurance in 1984 and 1985, but substantially greater than the percentage that reported no health insurance in the early 1980s. In 1982, less than 16 percent of the nonelderly civilian population were uninsured.

Who are the uninsured?

In 1986, more than one-half of the uninsured (51 percent, or 18.9 million people) were workers. Another one-third (31 percent, or 11.4 million people) were children under age 18. Only 18 percent of the uninsured (6.7 million people) were nonworking adults.

More than 95 percent of the uninsured population were either themselves workers or lived in families of workers. For about one-half of the uninsured, either the uninsured individual or their family head was a full-time, full-year worker (that is, a worker who worked or sought work at least 35 weeks in 1986 and worked at least 35 hours in a typical week) and reported no unemployment during the year. In 1986, nearly half of the uninsured population (47.8 percent, or 18 million people) lived in families of such workers: full-time, full-year and steadily employed. Another 22 percent of the uninsured population (8.2 million people) lived in families of full-year workers who reported one or more weeks of unemployment during the year. About 18 percent of the uninsured population (6.5 million people) lived in families where the family head was either a part-year worker (for example, a seasonal worker) or a part-time worker. Twelve percent lived in nonworker families.

Economic and family status of the uninsured

The uninsured population live predominantly, but not exclusively, in low and middle-income families. About one-half of the uninsured population (50.5 percent) reported family income of less than $15,000 in 1986; more than three-quarters (77.2 percent) reported family income of less than $30,000. However, nearly 14 percent of the uninsured reported family income that exceeded $40,000 in 1986.

About one-third of the uninsured population (32.1 percent, or 11.9 million people) reported family income (adjusted for family size) below the federal poverty standard. Nearly one-half (48.9 percent) reported family income that was less than 150 percent of the poverty standard. In 1986, the federal poverty standard for a family of four was $11,203.

In 1986, more than one-half of the uninsured population (58.7 percent) lived in families with children; one-quarter lived in single-parent families with children. Among the uninsured poor or near-poor population (with family income less than 125 percent of the poverty standard), two-thirds (67.8 percent) lived in families with children; more than one-third (36.3 percent) lived in single-parent families with children. About one-quarter of the uninsured (26.1 percent) were single adults without children.

The rate of noncoverage among some family types in particular economic situations is especially high, even though these family types may not represent most of the uninsured. For example, among people living in single-parent families with children in 1986, nearly one-third (30.1 percent) were uninsured, compared to less than 18 percent among the nonelderly population as a whole. This high rate of noncoverage in part reflects the predominantly low incomes of single-parent families.

Among all low-income families, however, single-parent families are somewhat more likely than two-parent families to be insured, principally because of better access to Medicaid. In 1986, 38 percent of poor and near poor people in two-parent families with children were uninsured (compared to 32.5 percent of those in single-parent families). Because of disqualification from Medicaid, in both single-parent and two-parent familiesin poverty or near-poverty, people were more likely to be uninsured (46.3 percent and 39.8 percent, respectively) if the family included a full-year worker.

The rate of noncoverage among poor or near-poor families without children is especially high. In 1986, 45 percent of poor or near-poor married people without children had no insurance from any source; where at least one family member was a full-year worker, one-half had no insurance. Among poor or near-poor single adults without children, nearly 52 percent were uninsured; among those who were full-year workers, 57 percent were uninsured.

Noncoverage within states: urban and rural areas

Rates of noncoverage across the country differ significantly among the states, largely as a consequence of differences in employer coverage and Medicaid eligibility. In 14 states[2] and the District of Columbia, more than 20 percent of the nonelderly population were uninsured in 1986. In Mississippi, Texas and New Mexico, more than one-quarter of the nonelderly population were uninsured.

In general, the rural population in the United States is less likely to have health insurance than the urban population. In 1986, 17.4 percent of the urban population (people residing in Census-designated metropolitan statistical areas or their suburbs) were uninsured, compared to 19.1 percent of the rural population. Among the rural population, agricultural workers and members of their families report especially high rates of noncoverage: nearly 32 percent of agricultural workers and their families were uninsured in 1986. Among the agricultural population in poverty, nearly 49 percent were uninsured.

Noncoverage among workers

Employer plans are the predominant source of health insurance among workers and their families. In 1986, nearly three-quarters of all workers (74.7 percent, or 88.1 million workers) were covered by an employer health insurance plan. However, 15.4 percent of workers reported having no health insurance from any source.

Most uninsured workers in 1986 (59.9 percent) were full-year, full-time workers; that is, they worked or sought work 35 weeks or more in 1986 and worked at least 35 hours in a typical week. Other uninsured workers were approximately evenly divided between part-year workers (including seasonal workers) and part-time workers.

In general, young workers are substantially less likely than older workers to have insurance coverage, either from an employer plan or from any other source. In 1986, 58 percent of workers age 21 to 24 were covered by an employer plan; nearly one-quarter (24.4 percent) had no health insurance from any source. By comparison, nearly 88 percent of workers age 45-54 had employer coverage, and only 10 percent reported having no health insurance.

Men and women in the workforce are about equally likely to have health insurance from an employer plan, but women are more likely to qualify for public insurance coverage -- in particular, Medicaid. As a result, women

workers are slightly less likely to be uninsured than their male counterparts. In 1986, 14.1 percent of women workers had no health insurance from any source, compared to 16.5 percent of working men. Women in the workforce, however, are substantially more likely than men to obtain employer coverage only as a dependent, rather than as a benefit from their own employer. In 1986, two-thirds of working men obtained employer coverage as a direct benefit of employment, while about one-half of working women (51.9 percent) obtained employer health coverage directly.

Most uninsured workers earn relatively little on their jobs. In 1986, nearly three-quarters of uninsured workers (73.6 percent) earned less than $10,000 that year; 34 percent earned less than the federal minimum wage. Nearly all (92.3 percent) earned less than $20,000. Among workers that earned less than $10,000 in 1986, 29 percent were uninsured.

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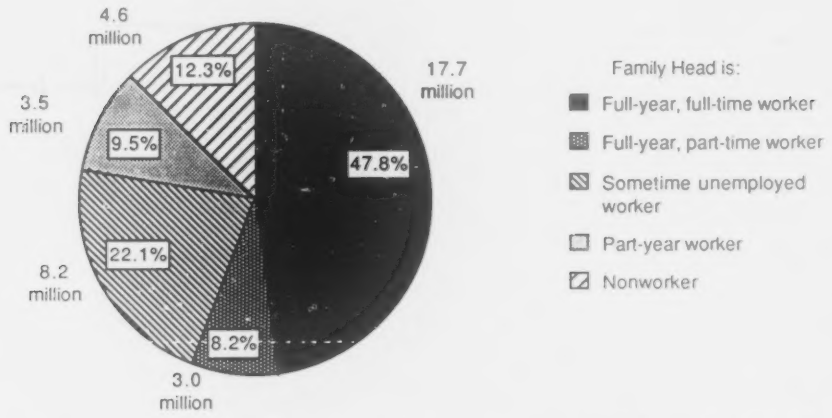
[1]The data presented here are not strictly comparable to those that EBRI published in 1987. These data include agricultural workers and their families, but exclude all people living in families of military personnel; the 1987 publication excluded both groups.

[2]Alabama, Alaska, Arizona, Arkansas, California, Florida, Idaho, Kentucky, Louisiana, Mississippi, New Mexico, Oklahoma, Tennessee and Texas.

Nonelderly Population Without Health Insurance by Employment Status of Family Head, 1986



Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.

Nonelderly Population by Selected Sources of Health Insurance and Own Work Status, 1986

Own Work Status	Total	Insured Population: Private & Public							No Health Insurance Coverage
		Total	Total Private	Employer-provided			Public		
				Total	Direct	Indirect	Total	Medicaid	
				(in millions)					
Total	208.0	171.0	152.9	136.1	70.2	65.9	24.9	17.0	37.0
Family Head									
Workers	73.6	62.5	60.0	55.0	52.8	2.1	4.7	2.4	11.1
Other Family									
Workers	48.4	40.6	39.5	36.1	17.4	18.7	2.3	0.9	7.8
Nonworkers	86.1	68.0	53.4	45.1	a	45.1	17.9	13.7	18.1
Children	58.1	46.7	38.9	35.9	a	35.9	9.4	8.2	11.4
Others	86.1	21.3	14.5	9.2	a	9.2	8.5	5.5	6.7
				(percent within worker categories)					
Total	100.0%	82.2%	73.5%	65.4%	33.8%	31.7%	12.0%	8.2%	17.8%
Family Head									
Workers	100.0	84.9	81.6	74.7	71.8	2.9	6.3	3.3	15.1
Other Family									
Workers	100.0	83.9	81.8	74.6	36.0	38.6	4.7	1.8	16.1
Nonworkers	100.0	78.9	62.0	52.4	a	52.4	20.8	15.9	21.1
Children	100.0	80.4	66.9	61.8	a	61.8	16.3	14.2	19.6
Others	100.0	24.7	16.8	10.7	a	10.7	9.9	6.4	7.8
				(percent within source of coverage groups)					
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Family Head									
Workers	35.4	36.5	39.2	40.4	75.2	3.2	18.8	14.2	30.0
Other Family	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Workers	23.2	23.7	25.9	26.5	24.8	28.3	9.1	5.1	21.0
Nonworkers	41.4	39.8	34.9	33.1	a	68.5	72.1	80.8	49.0
Children	27.9	27.3	25.4	26.4	a	54.5	37.9	48.5	30.7
Others	41.4	12.4	9.5	6.8	a	14.0	34.2	32.2	18.2

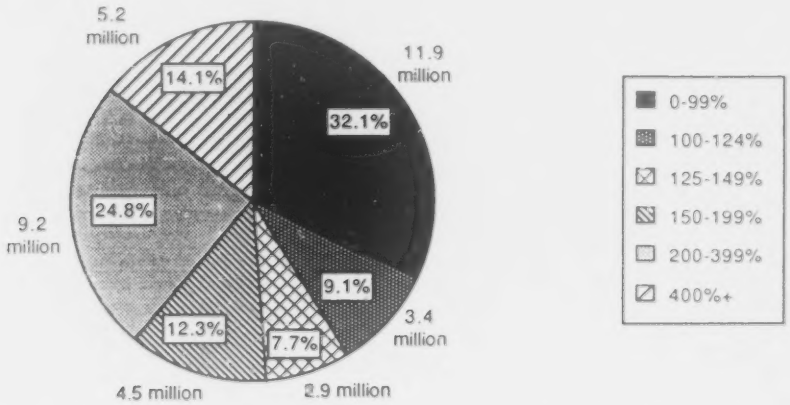
Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.
a--Number too small to be statistically reliable

Nonelderly Population by Selected Sources of Health Insurance and Family Income, 1986

Family Income	Total	Insured Population: Private & Public							No Health Insurance Coverage
		Total	Total Private	Employer-provided Total	Employer-provided Direct	Employer-provided Indirect	Public Total	Public Medicaid	
				(in millions)					
Total	208.0	191.0	152.9	136.1	70.2	65.9	24.9	17.0	37.0
Under $5,000	15.2	8.7	2.5	1.0	0.6	0.4	6.8	6.4	6.2
$5,000-$9,999	17.1	11.4	5.0	3.2	2.1	1.1	6.5	5.8	6.3
$10,000-$14,999	18.5	16.3	10.1	7.9	4.8	3.1	3.1	2.2	6.2
$15,000-$19,999	18.3	17.3	13.0	11.0	6.1	4.9	1.7	1.0	4.3
$20,000-$29,999	37.8	36.9	31.0	27.6	14.0	13.6	2.5	0.9	5.6
$30,000-$39,999	34.2	33.8	30.4	28.0	13.6	14.4	1.6	0.4	3.3
$40,000 or More	66.9	66.6	61.1	57.4	29.0	28.4	2.5	0.3	5.1
				(percents within income groups)					
Total	100.0%	91.8%	73.5%	65.4%	33.8%	31.7%	12.0%	8.2%	17.8%
Under $5,000	100.0	57.5	16.4	6.6	4.2	2.3	45.0	42.5	40.9
$5,000-$9,999	100.0	66.4	29.0	18.9	12.3	6.7	38.0	33.6	36.9
$10,000-$14,999	100.0	88.0	54.3	42.9	26.1	16.9	17.0	12.0	33.4
$15,000-$19,999	100.0	94.7	70.9	59.9	33.2	26.7	9.5	5.3	23.3
$20,000-$29,999	100.0	97.5	82.0	73.0	36.9	36.1	6.7	2.5	14.9
$30,000-$39,999	100.0	98.9	88.7	81.7	39.7	42.0	4.7	1.1	9.6
$40,000 or More	100.0	99.6	91.3	85.9	43.4	42.4	3.8	0.4	7.7
				(percents within source of coverage groups)					
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Under $5,000	7.3	4.6	1.6	0.7	0.9	0.5	27.4	37.9	16.7
$5,000-$9,999	8.2	6.0	3.3	2.4	3.0	1.7	26.2	33.9	17.1
$10,000-$14,999	8.9	8.5	6.6	5.8	6.9	4.7	12.6	13.1	16.7
$15,000-$19,999	8.8	9.1	8.5	8.1	8.7	7.4	7.0	5.7	11.5
$20,000-$29,999	18.2	19.3	20.3	20.3	19.9	20.7	10.2	5.5	15.2
$30,000-$39,999	16.5	17.7	19.9	20.5	19.4	21.8	6.5	2.3	8.9
$40,000 or More	32.2	34.9	39.9	42.2	41.3	43.1	10.1	1.5	13.9

Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.

Nonelderly Population Without Health Insurance by Family Income as a Percent Of Poverty, 1986



Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.

Nonelderly Population with Selected Sources of Health Insurance by Family Type, Family Head's Employment Status and Family Poverty Status, 1986

Family Type and Employment Status of Family Head	Total	Insured Population: Private & Public							No Health Insurance Coverage
		Total	Total Private	Employer-provided			Public		
				Total	Direct	Indirect	Total	Medicaid	
				(in millions)					
				Total Population					
Total	208.0	171.0	152.9	136.1	70.2	65.9	24.9	17.0	37.0
Child Present									
Spouse Present	99.1	86.6	82.5	77.4	26.6	50.8	6.9	4.2	12.4
Full-year worker	94.8	83.6	81.0	76.4	26.3	50.1	5.1	2.8	11.2
Part-year worker	2.5	1.8	1.3	0.9	0.3	0.6	0.6	0.5	0.7
Nonworker	1.8	1.3	0.2	a	a	a	1.2	1.0	0.5
No Spouse Present	31.0	21.7	12.1	10.0	5.2	4.8	10.5	9.9	9.3
Full-year worker	19.1	12.8	10.7	9.4	4.9	4.5	2.8	2.4	6.3
Part-year worker	3.9	2.6	1.1	0.6	0.3	0.3	1.7	1.6	1.3
Nonworker	8.0	6.3	0.4	a	a	a	6.1	5.9	1.7
No Child Present									
Spouse Present	42.3	36.6	35.1	30.0	20.3	9.7	3.6	0.7	5.6
Full-year worker	37.2	32.7	32.0	29.1	19.8	9.3	2.3	0.3	4.5
Part-year worker	1.8	1.4	1.3	0.8	0.5	0.3	0.2	a	0.4
Nonworker	3.3	2.5	1.9	a	a	a	1.1	0.3	0.8
No Spouse Present	35.7	26.0	23.1	18.8	18.2	0.6	3.8	2.1	9.7
Full-year worker	28.9	21.9	20.9	18.2	17.6	0.6	1.7	0.7	6.9
Part-year worker	2.5	1.4	1.2	0.6	0.6	a	0.3	0.2	1.1
Nonworker	4.3	2.7	1.0	a	a	a	1.8	1.2	1.7
				Poor and Near-Poor Population (0-125% of Poverty)					
Total	39.6	24.3	10.6	7.1	3.1	4.0	15.2	14.0	15.2
Child Present									
Spouse Present	12.7	7.9	5.1	4.1	1.1	2.9	3.3	3.0	4.8
Full-year worker	10.3	6.2	4.7	3.9	1.1	2.8	1.9	1.8	4.1
Part-year worker	1.0	0.6	0.3	0.2	a	0.1	0.4	0.3	0.4
Nonworker	1.5	1.1	0.1	a	a	a	1.0	0.9	0.3
No Spouse Present	17.0	11.5	2.7	1.8	0.9	1.0	9.4	9.2	5.5
Full-year worker	6.3	3.4	1.9	1.6	0.7	0.8	1.9	1.7	2.9
Part-year worker	3.0	1.9	0.5	0.3	0.1	0.1	1.6	1.5	1.1
Nonworker	7.7	6.1	0.3	a	a	a	6.0	5.9	1.6
No Child Present									
Spouse Present	2.3	1.3	0.9	0.3	0.2	0.1	0.5	0.3	1.0
Full-year worker	1.1	0.5	0.5	0.3	0.2	0.1	0.1	a	0.5
Part-year worker	0.3	0.2	0.1	a	a	a	a	a	0.1
Nonworker	1.0	0.6	0.3	a	a	a	0.4	0.2	0.4
No Spouse Present	7.5	3.6	1.9	0.9	0.9	a	1.9	1.5	3.9
Full-year worker	3.3	1.4	1.1	0.7	0.7	a	0.4	0.3	1.9
Part-year worker	1.3	0.6	0.4	0.2	0.2	a	0.2	0.2	0.7
Nonworker	3.0	1.6	0.4	a	a	a	1.3	1.0	1.3

Nonelderly Population with Selected Sources of Health Insurance by Family Type, Family Head's Employment Status and Family Poverty Status, 1986
(Continued)

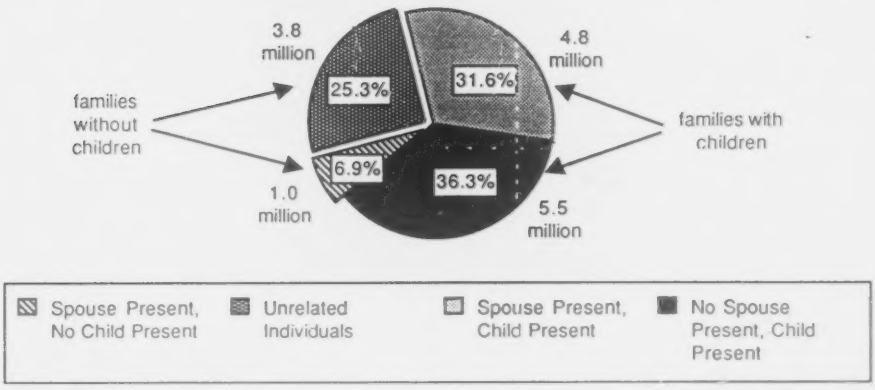
Family Type and Employment Status of Family Head	Total	Insured Population: Private & Public							No Health Insurance Coverage
		Total	Total Private	Employer-provided Total	Employer-provided Direct	Employer-provided Indirect	Public Total	Public Medicaid	
		(Percent within family type/employment group)							
Total Population									
Total	100.0%	82.2%	73.5%	65.4%	33.8%	31.7%	12.0%	8.2%	17.8%
Child Present									
Spouse Present	100.0	87.5	83.3	78.1	26.8	51.3	7.0	4.3	12.5
Full-year worker	100.0	88.2	85.5	80.6	27.7	52.9	5.4	2.9	11.8
Part-year worker	100.0	70.4	53.9	38.0	13.0	25.0	25.2	18.9	29.6
Nonworker	100.0	74.1	11.9	a	a	a	64.9	54.7	25.9
No Spouse Present	100.0	69.9	39.2	32.2	16.7	15.5	34.0	31.9	30.1
Full-year worker	100.0	67.0	55.8	49.0	25.6	23.4	14.6	12.4	33.0
Part-year worker	100.0	65.6	27.2	15.3	7.1	8.2	43.7	41.0	34.4
Nonworker	100.0	79.0	5.0	a	a	a	75.9	74.5	21.0
No Child Present									
Spouse Present	100.0	86.7	83.2	70.9	48.0	22.9	8.5	1.7	13.3
Full-year worker	100.0	88.0	86.0	78.2	53.1	25.1	6.1	0.9	12.0
Part-year worker	100.0	78.4	72.4	47.7	28.6	19.1	13.3	a	21.6
Nonworker	100.0	77.0	56.7	a	a	a	32.3	10.4	23.0
No Spouse Present	100.0	72.9	64.7	52.8	51.0	1.8	10.7	5.9	27.1
Full-year worker	100.0	76.0	72.3	63.0	60.9	2.1	5.8	2.5	24.0
Part-year worker	100.0	57.0	46.7	25.6	24.3	a	12.9	7.7	43.0
Nonworker	100.0	61.7	24.1	a	a	a	42.4	27.6	38.3
Poor and Near-Poor Population (0-125% of poverty)									
Total	100.0%	61.5%	26.7%	18.1%	7.8%	10.2%	38.3%	35.3%	38.5%
Child Present									
Spouse Present	100.0	62.2	40.2	32.0	9.0	23.0	26.3	23.8	37.8
Full-year worker	100.0	60.2	45.7	37.7	10.5	27.2	18.9	17.0	39.8
Part-year worker	100.0	61.4	30.4	18.4	a	12.3	37.5	33.7	38.6
Nonworker	100.0	77.0	8.0	a	a	a	70.8	64.5	23.0
No Spouse Present	100.0	67.5	15.8	10.9	5.1	5.8	55.5	53.9	32.5
Full-year worker	100.0	53.7	29.8	24.9	11.7	13.3	29.5	27.4	46.3
Part-year worker	100.0	64.8	17.0	9.1	4.4	4.7	53.3	51.1	35.2
Nonworker	100.0	79.8	3.9	a	a	a	77.8	76.8	20.2
No Child Present									
Spouse Present	100.0	55.4	37.5	13.5	8.5	5.0	21.3	13.0	44.6
Full-year worker	100.0	50.0	42.6	23.7	14.4	9.3	8.8	a	50.0
Part-year worker	100.0	53.8	40.0	a	a	a	a	a	46.2
Nonworker	100.0	62.1	31.2	a	a	a	36.6	21.9	37.9
No Spouse Present	100.0	48.5	25.3	12.2	11.9	a	25.1	19.8	51.5
Full-year worker	100.0	43.0	32.6	21.4	20.8	a	11.8	9.5	57.0
Part-year worker	100.0	48.1	34.1	16.8	16.6	a	16.2	12.1	51.9
Nonworker	100.0	54.9	13.5	a	a	a	43.6	34.4	45.1

Nonelderly Population with Selected Sources of Health Insurance by Family Type, Family Head's Employment Status and Family Poverty Status, 1986
(Continued)

Family Type and Employment Status of Family Head	Total	Insured Population: Private & Public							No Health Insurance Coverage
		Total	Total Private	Employer-provided			Public		
				Total	Direct	Indirect	Total	Medicaid	
	(Percent within coverage group)								
Total Population									
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Child Present									
Spouse Present	47.6	50.7	54.0	56.8	37.9	77.1	27.9	25.0	33.5
Full-year worker	45.6	48.9	53.0	56.1	37.4	76.1	20.6	16.4	30.3
Part-year worker	1.2	1.0	0.9	0.7	0.5	0.9	2.5	2.8	2.0
Nonworker	0.9	0.8	0.1	a	a	a	4.7	5.8	1.3
No Spouse Present	14.9	12.7	7.9	7.3	7.4	7.3	42.4	58.3	25.2
Full-year worker	9.2	7.5	7.0	6.9	7.0	6.8	11.2	13.9	17.1
Part-year worker	1.9	1.5	0.7	0.4	0.4	0.5	6.8	9.4	3.6
Nonworker	3.8	3.7	0.3	a	a	a	24.3	35.0	4.5
No Child Present									
Spouse Present	20.3	21.4	23.0	22.0	28.9	14.7	14.4	4.3	15.2
Full-year worker	17.9	19.1	20.9	21.4	28.1	14.2	9.1	2.0	12.1
Part-year worker	0.9	0.8	0.8	0.6	0.7	0.5	0.9	a	1.0
Nonworker	1.6	1.5	1.2	a	a	a	4.3	2.0	2.1
No Spouse Present	17.2	15.2	15.1	13.8	25.9	1.0	15.4	12.4	26.1
Full-year worker	13.9	12.8	13.7	13.4	25.0	0.9	6.7	4.2	18.8
Part-year worker	1.2	0.8	0.8	0.5	0.9	a	1.3	1.1	2.9
Nonworker	2.1	1.6	0.7	a	a	a	7.4	7.0	4.5
Poor and Near-Poor Population (0-125% of poverty)									
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Child Present									
Spouse Present	32.2	32.6	48.4	56.9	36.8	72.3	22.0	21.7	31.6
Full-year worker	26.0	25.4	44.4	54.2	34.8	69.1	12.8	12.5	26.9
Part-year worker	2.5	2.5	2.8	2.6	a	3.0	2.5	2.4	2.5
Nonworker	3.7	4.6	1.1	a	a	a	6.8	6.7	2.2
No Spouse Present	43.0	47.2	25.4	25.9	28.1	24.2	62.2	65.6	36.3
Full-year worker	16.0	14.0	17.8	22.1	23.8	20.7	12.3	12.4	19.2
Part-year worker	7.6	8.0	4.8	3.8	4.3	3.5	10.5	10.9	6.9
Nonworker	19.4	25.2	2.8	a	a	a	39.4	42.2	10.2
No Child Present									
Spouse Present	5.9	5.4	8.3	4.4	6.4	2.9	3.3	2.2	6.9
Full-year worker	2.8	2.3	4.4	3.6	5.1	2.5	0.6	a	3.6
Part-year worker	0.7	0.6	1.1	a	a	a	a	a	0.9
Nonworker	2.5	2.5	2.9	a	a	a	2.3	1.5	2.4
No Spouse Present	18.9	14.9	17.9	12.8	28.7	a	12.4	10.6	25.3
Full-year worker	8.3	5.8	10.1	9.8	21.9	a	2.6	2.2	12.3
Part-year worker	3.2	2.5	4.0	2.9	6.7	a	1.3	1.1	4.3
Nonworker	7.5	6.7	3.8	a	a	a	8.5	7.3	8.8

Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.
a-Numbers too small to be statistically reliable.

Poor and Near Poor Nonelderly Population Without Health Insurance by Family Status, 1986



Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.

Percent of Nonelderly Population with Selected Sources of Health Insurance by Region and State, 1986

Region by State	Total	Total Private	Total Employer	Other Private	Total Public	Medicaid	No Health Insurance Coverage
	(in thousands)						
Total.	208,023	73.5%	65.4%	11.5%	12.0%	8.2%	17.8%
New England	10,916	80.7	72.7	10.9	9.1	5.4	12.2
Maine	953	76.8	66.6	12.4	11.0	a	15.2
New Hampshire	883	84.4	78.0	11.3	a	a	11.5
Vermont	461	77.9	70.6	a	a	a	14.8
Massachusetts	5,085	80.5	72.5	10.4	10.1	7.9	11.9
Rhode Island	824	85.0	76.9	11.4	10.1	a	8.4
Connecticut	2,710	80.2	72.7	12.9	10.7	6.7	12.7
Middle Atlantic	31,893	76.5	69.2	10.5	11.5	9.3	14.3
New York	15,286	72.3	65.6	10.1	13.1	11.2	16.7
New Jersey	6,682	80.7	72.7	10.9	8.8	6.8	12.4
Pennsylvania	9,925	80.2	72.4	10.7	10.9	8.3	11.9
East North Central	36,378	76.8	69.4	10.7	12.3	9.5	14.1
Ohio	9,350	76.5	69.5	10.0	11.1	9.0	15.1
Indiana	4,654	78.0	70.0	11.6	7.4	3.9	17.9
Illinois	10,093	75.4	67.8	10.6	13.2	10.3	14.7
Michigan	8,133	76.2	69.3	10.6	16.1	12.7	11.9
Wisconsin	4,143	81.3	73.1	11.5	11.3	8.5	10.7
West North Central	15,209	78.5	65.8	16.2	10.2	7.7	13.9
Minnesota	3,670	79.9	65.9	17.3	12.9	10.8	10.6
Iowa	2,532	80.4	64.8	19.6	11.1	9.3	11.6
Missouri	4,391	75.8	67.0	10.7	10.7	7.8	16.3
North Dakota	548	80.8	59.2	26.0	a	a	15.9
South Dakota	595	77.9	58.6	23.2	a	a	17.4
Nebraska	1,383	77.3	64.8	17.3	9.4	6.2	16.9
Kansas	2,090	80.1	68.4	16.3	9.0	5.1	14.3
South Atlantic	34,639	73.8	65.6	11.7	11.2	6.1	18.5
Delaware	553	76.1	70.0	a	a	a	17.8
Maryland	3,972	78.9	72.2	10.0	8.8	5.3	15.5
District of Columbia	526	69.4	62.5	a	a	a	21.2
Virginia	4,799	79.4	72.2	9.8	13.0	5.4	13.0
West Virginia	1,621	68.2	59.2	11.7	18.3	13.5	18.2
North Carolina	5,364	74.5	66.6	12.0	9.9	5.5	18.4
South Carolina	2,840	73.7	66.5	11.6	14.3	8.2	16.5
Georgia	5,311	73.3	66.3	11.4	12.7	8.1	18.0
Florida	9,653	70.1	59.3	14.6	10.4	4.9	23.2

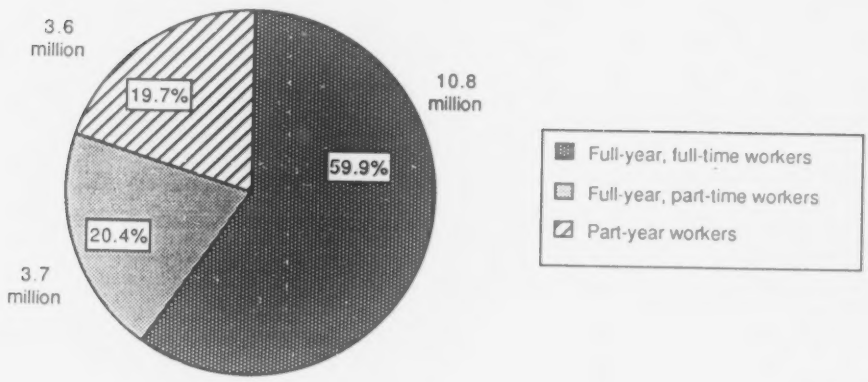
Percent of Nonelderly Population with Selected Sources of Health Insurance by Region and State, 1986
(Continued)

Region by State	Total	Total Private	Total Employer	Other Private	Total Public	Medicaid	No Health Insurance Coverage
East South Central	12,973	66.7	59.1	11.8	13.9	9.1	22.7
Kentucky	3,139	68.5	60.4	10.8	14.3	9.7	21.0
Tennessee	4,010	68.0	60.6	11.7	15.5	9.5	20.6
Alabama	3,575	66.5	60.0	10.2	12.0	8.2	24.0
Mississippi	2,249	62.4	53.2	15.6	13.5	9.1	26.9
West South Central	23,290	66.5	59.4	11.1	11.4	6.6	25.2
Arkansas	2,007	65.3	57.4	12.3	14.7	8.2	24.3
Louisiana	3,920	65.0	57.0	13.3	15.3	10.6	23.1
Oklahoma	2,793	69.6	60.5	12.6	11.9	5.5	22.8
Texas	14,569	66.5	60.1	10.1	9.8	5.5	26.3
Mountain	11,354	73.6	63.3	13.0	9.6	2.7	19.7
Montana	715	73.5	57.0	21.5	12.4	a	18.8
Idaho	863	72.5	60.7	15.3	a	a	22.7
Wyoming	441	74.6	64.1	a	a	a	17.6
Colorado	2,709	74.1	64.2	13.5	13.9	7.2	16.3
New Mexico	1,249	66.3	53.6	15.2	11.4	a	26.1
Arizona	2,895	73.5	63.3	13.6	7.6	a	22.5
Utah	1,546	76.4	69.9	9.0	10.0	6.8	16.4
Nevada	878	77.7	70.3	11.3	10.8	a	17.6
Pacific	31,369	69.2	62.0	9.7	13.6	9.6	20.5
Washington	3,808	71.9	62.9	11.7	17.2	11.0	15.8
Oregon	2,401	73.0	65.5	9.1	9.7	7.0	19.9
California	23,874	67.9	61.3	9.3	13.7	10.2	21.5
Alaska	453	71.6	59.8	a	a	a	21.5
Hawaii	833	80.6	70.4	18.5	12.5	a	12.9

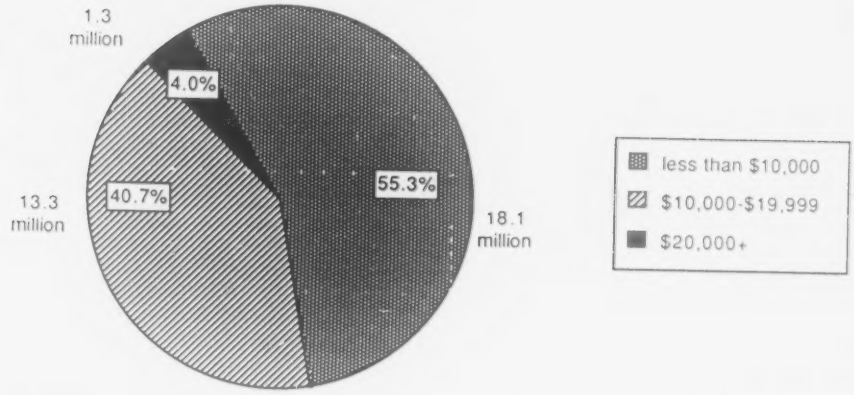
Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.

a--Values too small to be statistically reliable.

Workers Age 18-64 Without Health Insurance by Own Work Status, 1986



Workers Age 18-64 Without Health Insurance by Personal Earnings, 1986



Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155-3815

August 19, 1988

The Honorable George Mitchell
United States Senator, Chair
Senate Finance Subcommittee on Health
SD-205
Washington, D.C. 20510

Dear Senator Mitchell,

Thank you for the opportunity to include a written statement for the printed record of your hearing on the uninsured.

The national concern for persons without health care coverage is paralleled in Minnesota. Five studies have recently been completed by various state agencies and community groups in Minnesota addressing the uninsured population, their problems and their health care providers' problems. The facts uncovered through our studies are dramatic. More than 350,000 Minnesotans are not insured. One-third of our uninsured population are children under age 18, and another one-third are between the ages of 19 and 25. Health insurance is heavily subsidized in this state, 60 percent of the population is covered through employment plans and 21 percent through public programs. The remaining 19 percent of the population is without access to a subsidized health care plan, and while over half of them purchase individual insurance, their premium is higher, and their coverage is less. A substantial portion of this group is underinsured because the deductible amount is a financial barrier to necessary health care.

Being employed is not an indication of having health coverage. Of uninsured unmarried adults over 19 years of age, 25 percent were not employed at all, 35 percent were employed for part of the year, and 40 percent were fully employed. Workers in part time or low paying jobs are more likely to be uninsured, and this group is expected to increase as employers' budget cutbacks force greater use of temporary and part-time workers.

Minnesota has initiated programs to address specific problems. On July 1st, we implemented the Children's Health Plan for uninsured children, ages 1 through 8, in families with income less than 185 percent of the federal poverty guidelines and expanded our Medicaid Program to pregnant women and infants up to one year old with family incomes less than 185 percent of the federal poverty guidelines. Both of these programs stress preventive care services to populations for whom these services are most cost effective. The Children's Health Plan does not cover any inpatient services but it does provide access to physician office visits, dental care, vision care and eye glasses, therapies, and outpatient services. Medical Assistance, our Medicaid Program, was expanded to include additional reimbursement and services for comprehensive perinatal services, including educational services for low income women at risk for pre-term or low birth weight babies.

Health care coverage is also recognized as an important adjunct to welfare reform efforts in our state. Jobs and child care contribute to self-sufficiency but the stress created by the absence of health insurance can undermine many individual efforts. Seventy-five percent of the children enrolled in the Children's Health Plan are in families who have received some form of public assistance in the past, either income, medical, or food stamp assistance.

We continue to be interested in, and to support, consideration of health care coverage for uninsured Minnesotans. Last spring, the Minnesota State Legislature passed a bill which directs the Department of Human Services to prepare a set of implementation options for a state-subsidized health plan for Minnesota's uninsured. This plan was conceptualized in a 1987 Department of Health study entitled, "The Challenge of Providing Financial Access to Health Care in Minnesota".

The legislative options now under development by the Department of Human Services will aid state policy-making on the problems of the uninsured by promoting informed discussion of the benefits, costs, and related implications of alternative approaches. Issues of eligibility, benefit design, program costs, employer participation, administration, funding, and coordination with other public programs will be examined. This presentation and analysis of implementation pathways will help legislators determine Minnesota's next step toward closing the financial access gap to health care during the upcoming biennium. Adequate health insurance for all is a direct benefit to people who do not have it, and an indirect benefit to society as a whole. States cannot go alone because it requires congressional assistance financially and administratively. A national commitment is necessary to assure everyone the right to appropriate and affordable health care.

Sincerely,

SANDRA S. GARDEBRING
Commissioner

cc: Tom Lehman
State of Minnesota
Washington, D.C. Office

U.S. SMALL BUSINESS ADMINISTRATION
WASHINGTON, D.C. 20416

July 25, 1988

Honorable George J. Mitchell
Chairman
Subcommittee on Health
Senate Finance Committee
U.S. Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am requesting that this letter be included in the record for the July 25, 1988, hearing on Access to Health Care being held by the Subcommittee on Health. As Chief Counsel for Advocacy of the Small Business Administration, I am authorized to represent the views and interests of small business before Congress and other Federal agencies. The provision of health care to workers is an issue of paramount concern to small business owners; they recognize the needs of their employees to have insurance and are aware that they must provide adequate benefits if they are to attract capable and loyal employees.

My interest and knowledge regarding health care cost and coverage stems from extensive involvement with the 1986 White House Conference on Small Business and the Office of Advocacy's commission of a landmark study on the costs and benefits of employer-provided health care conducted by ICF in 1987.[1] In addition, there has been a follow-up survey to this study to look more closely at the record of very small businesses, one to nine employees.[2]

There is no question that small employers will have to address the access to health care issue, partly due to the changes in the labor supply. With the rate of growth in the labor pool declining for the next several years, small business will have to be stronger competitors for workers. In addition, the internationalization of the American economy is shifting the small business environment from the traditionally stable U.S. economy to more volatile, international markets. It is imperative that to meet the changes projected by the year 2000, small employers' flexibility in meeting their workforce needs not be unduly restricted.

Fully mandated access to health care legislation presently under discussion does not solve problems of supply, cost, and the overriding issue for determining health care offerings by a small employer--profitability. Nor do access bills ameliorate the impact of the change such an approach would cause to hiring patterns of existing companies and increasing start-up costs for new employers. Small business has a well-documented record as job creators generating two out of three new jobs over the past seven years. Part of the reason for their success in adding new jobs has been their flexibility to mold the hours employees work and the degree to which they can tailor their benefit packages.

To understand the importance of this flexibility in offering health care and other benefit packages to employees, it is necessary to have a picture of small business health care coverage as it presently exists and to understand the special characteristics of small firms.

Characteristics of Small Business Employer Coverage

In April 1987 the U.S. Small Business Administration released a study by Lewin/ICF on Health Care Coverage in Small and Large Businesses. The findings of the study are important for this hearing.

Not surprisingly, the prevalence of health care increases with firm size. Forty-five percent of U.S. firms with fewer than ten workers offer health insurance compared to nearly 100 percent of firm with 500 or more employees. Seventy-eight percent of firms with 10-24 workers, 92 percent of firms with 25-99 workers, and 98 percent of firms with 100-499 workers offer health plans to some or all of their workers.

Small firms are less likely to offer health benefits for a variety of reasons, including: higher per capita premium costs because risk per capita is higher in small groups, tax advantages associated with offering health insurance--particularly sole proprietorships, which comprise about 85 percent of small business--do not benefit small firms to the same extent as large firms, the fixed costs of choosing and administering health plans are higher, and higher employee turnover rates and greater use of part-time and seasonal employees increase administrative fees for small firms relative to large.

For both single and family coverage, small businesses pay as much as 40 percent higher premiums than large firms. Small business owners have less negotiating power with an insurer when purchasing a benefit package and reflects the higher expenses which insurers incur in servicing smaller plans.

The Decision to Offer Health Care Coverage

In 1988, Lewin/ICF performed a follow-up survey to see if any changes in coverage had occurred since the original study and to examine some additional characteristics of very small firms.[3] All of the original firms with one to nine employees that indicated that they did not offer health care in the earlier study were contacted. The findings from that study are useful to these hearings.

Of the original firms surveyed, 18 percent have started to offer insurance, and 82 percent still do not. For those firms still not offering insurance, 43 percent said they could not afford it and 34 percent said their employees were covered elsewhere.

In the firms that started to offer health insurance, there were more full time workers than in firms without health coverage. The average payroll and salary were higher in firms offering insurance. In firms with insurance the estimated annual salary for full-time equivalent workers was $15,600 compared to $7,400 in firms without insurance.

The average revenue for firms offering insurance was $845,000 compared to $232,000 in firms not offering insurance. Firms starting to offer insurance experienced an average increase in revenues of $186,000 over the past two years, and increased their workforce, on average, by four. Those not offering insurance saw a $39,000 increase in revenues and an increase in workers of one.

Recommendations for Increasing Coverage which Rely on Voluntary Initiatives

The sum of these differences indicates that firms not offering health insurance, are generally quite different than those that do. They still produce goods and services, they still employ people, but they have significantly less resources to provide presently available health benefits. A federal mandate does not change this.

We support a variety of initiatives that would increase voluntary employer coverage of small business workers, including the extension of a 100 percent tax deduction for health premiums for the self-employed, encouragement of the growing number of business and community groups around the country that are creating plans that offer a variety of approaches, costs, and centralized administration, provision for state establishment of Medicaid buy-in program, and exemption from current state mandated benefits in order to encourage private employers' purchase of low cost catastrophic coverage.

Several states have initiatives seeking to extend health care access. The Robert Wood Johnson Foundation has several pilot projects on medical services to the uninsured. There is a wide variety of approaches now being attempted by various state and nonprofit organizations. Some will be more successful than others. These local initiatives should be allowed to prove themselves out. We should not cut short the opportunity to learn from these many ongoing initiatives by moving toward a federal mandate.

The health care access issue is a complicated problem, involving many population groups, as well as employees, health care providers, insurers, employers and government. It is unlikely that a single, federally mandated solution will be the best solution to the wide range of health care access problems. We are in the ideal position to monitor and analyze the many state and local programs and approaches. It is too soon and we are not well enough informed to dictate a federal solution to health care access.

Yours very truly,

Frank S. Swain
Chief Counsel for Advocacy

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[1]"Health Care Coverage and Costs in Small and Large Businesses", ICF Incorporated, April 15, 1987.

[2]"Increases in Health Insurance Coverage in Small Firms 1986-88", Lewin/ICF, Incorporated, performed for the National Association for the Self-Employed.

[3]Id.

TESTIMONY OF FREDERICK D. HUNT, Jr.

SOCIETY OF PROFESSIONAL BENEFIT ADMINISTRATORS

UNCLE SAM VERSUS UNCLE SAM

Let's begin with an overview of the political history of benefit policy which shapes the attitudes of employers. From about 1935 to mid-1979, Uncle Sam encouraged womb-to-tomb employee benefits. The more the merier, and don't worry about the cost...it was tax dedcutible. In mid-1979 (note that neither political party is a villian nor angel), Uncle Sam suddenly recognized that his own finances were in trouble. At that point, Uncle Sam reversed his strategy, telling plans and employers that they were being entirely too generous with employees (with subsequent tax revenue loss). The impression sifted down during these years that employees should simply be paid for their work, taxed on that amount, and find individual coverage where and if they wanted. That philosophy held sway from 1979-1984, culminating in DEFRA (Tax Reform Act of 1984).

But DEFRA also marked the start of the next phase, during which Uncle Sam started what is called "cost-shifting." "Cost-shifting" occurs when Uncle Sam makes the promise of health coverage (such as the promise to military families, retirees, veterans, and elderly Americans on Medicare), but then tells the private emplyer who offers health coverage to foot the bill and keep Uncle Sam's promise. This "cost-shifting" still continues today, but with an added twist. Uncle Sam, taking a tip from state legislatures that have passed over 600 mandated benefits, has now started making promises for certain types of coverage and mandating employers who offer health coverage to provide them.

Now I ask you, if you were a business person trying to start or maintain a frim, would you want to get into this mess of conflicting congressional priorities and uncontrolled costs? Business people can see all of the different directives coming out of Washington, DC and their state insurance departments with a much more accurate perspective than you and I, who are often so involved in specific issues that we can't comprehend the overall picture and frustration. Their responses to all these varying mandates is clear: eliminate or reduce the amount of health coverage provided as an employee benefit in an attempt to control escalating costs. This employer response has been recently documented in a report from the Congressional Research Service which attributes the increase in the number of uninsured individuals to a decline in employer-provided dependent coverage.

In addition to the problem described above, the regulatory agencies impose their own conflicting interests and demands on employers who offer employee benefits. Since there are about 25 major federal agencies and over 50 state insurance departments that have some regulatory power over employee benefits, and since each of the 75 staunchly demands that it be the central authority on what it perceives to be its turf; you can imagine the confusion that constantly emerges. There are not only technical battles, but also basic philosophical disagreements. For instance: The Treasury Department and IRS have the goal of raising as much tax revenue as possible, thus cutting deductions and tax incentives. The Department of Labor has the goal of assuring as high and secure benefit levels as possible, no matter what the cost to employers. The Department of Health & Human Services (especially Medicare and Social Security) as well as the Veterans Administration, and Department of Defense (all prodded by OMB) have the goal of shifting as much of the cost for government-promised benefits onto private employers as possible. Finally, the EEOC and other offices want to promote "equality" and "fairness" in situations which are, by definition, individual in nature and thus not easy to define as "equal" or "fair." Once again, I ask: If you were a business manager watching all of this confusion, would you want your company to be caught as a yo-yo of reversing government priorities? I think your own answer to that question clarifies why some businesses that can afford to offer employee benefits avoid them.

Having started a small business myself, let me also give expert testimony to one other overwhelmingly important consideration. Brand new businesses, those in economically depressed areas, and those facing tough competition, are simply strapped for funds. I believe I have heard that half of all new businesses started each year fold within a year for lack of capital. If a firm is fighting for its life (and most small businesses not offering employee benefits fall into this category), health insurance is a luxury that simply can't be afforded. One fledgling businessman made the analogy that mandating health care is like telling a person who would love to have a car but can't afford one that he has to but one anyway, and maybe even pay for some estra options.

Thus, contradictory government policies which are churned around constantly by almost 1,000 new laws, regulations, rulings, interpretations, and other requirements each year are very discouraging disincentives. However, despite these disincentives, businesses have succeeded in forming some extremely successful health and pension programs. Let me discuss these types of plans.

TYPES OF HEALTH PLANS

There are four basic types of health insurance programs which have proved successful in extending coverage to individuals.

(1). Multi-employer union/management jointly-administered plans as authorized by the Taft-Hartley Act of 1946. These plans have proved to be especially valuable for carpenters, electricians, plumbers, and other types of workers who normally move from project (employer) to project on a daily, weekly, or monthly basis. Before Congress passed the Taft-Hartley Act, millions of these workers would not have been eligible for coverage, because they had little or no employer/employee relationship, and never would have been on one job long enough to qualify for coverage (or even process the papers, if coverage was offered from the first day). These Taft-Hartley plans have achieved their purpose extremely well.

Unfortunately, most legislators are not aware of Taft-Hartley plans and consequently create proposals that would harm these plans. The original legislation proposed by Senator Kennedy and your colleagues, Representatives Waxman, Clay, Murphy, and Hawkins, as S 1265 and HR 2508, "the Minimum Health Benefits for All Workers Act", would kill or starve to death the very efficient Taft-Hartley system; thus removing millions of currently covered workers from receiving employer health benefits. However, after discussions with Kennedy staff about the bill's effects, Senator Kennedy amended his bill to provide an allownace for Taft-Hartley plans. Despite this allowance, a number of provisions in S 1265 still threaten the financial well-being of these plans. If you or your colleagues decide to pursue HR 2508, we urge you to preserve the Taft-Hartley arrangement by amending the bill to ensure coverage of these itinerant workers.

(2). The second type of coverage for many business is the traditional insurance company fully-insured policy (such as a Blue Cross/Blue Shield policy). These policies served well for years. However, in recent years, the prices zoomed out of reach for many small employers and as businesses began to spread across state lines, the confusion caused by conflicting state regulations severely hurt this concept. Moreover, the birth of Health Maintenance Organizations (HMO) has increased the cost of the fully-insured policy. HMOs are normally offered as an extra or optional health plans, and usually attract the youngest and healthiest members of a workforce. For a large company which still has enough people left in the regular health plan to share the risk, the HMO works well. However, in a small employer situation, if the HMO takes the "cream of the crop", the remaining employees comprise the greatest risk and the employer is left with a smaller pool of employees who must share the worse-than-average risk which drives up cost. It is a no-win expensive dilemma for small employers. Thus, the HMO Act, with its mandated offering of HMOs and the "equal contribution" requirement (which is actually an extra profit center for the HMO), has infuriated and hurt many small employers who see it as another case of Uncle Sam's well-intentioned tinkering bring counter-productive.

(3). The third type of health coverage begins to show the recent innovations. Thousands upon thousands of businesses have successfully adapted a type of insurance called self-funding (self-insurance). I will brag hear and mention that our SPBA members have been

in the forefront of this innovation. Typically, in single-employer self-funded plans, the self-insurance risk is capped at two distinct points: a "specific" (meaning per-person) and an "aggregate" (meaning for the whole group) "attachment point". when paid losses rise above either of those dollar caps, a Stop-Loss insurance company begins to apy the claims and take the risk. Thus, this form of single-employer self-insurance (which has been successfully adapted for as few as 2 employees) might be envisioned as a very high-diductible insurance policy. The financial savings are tremendous because the employer takes the risk (and profits from lower claims, like an insurance company would) on the most active amounts of claims, and the Third Party Administrator (TPA) can customize the plan for the specific needs and wants of that employee group. The TPA also takes care of claims processing and payment as well as necessary communications with workers and government reporting.

Besides the government-induced problems mentioned earlier, there is a potential cloud that hangs over the head of these single-employer self-insured plans. They are dependent on the flukes of the Stop-Loss reinsurance marketplace. Since there is a natural love/hate relationship between these self-funded plans and the insurance companies from whom they are purchasing stop-loss, these single-employer self-funded plans are not only subject to the normal insurance marketplace fluctations, but they also worry about the potential threat of insurance company sabotage to bring these plans back into the more profitable fully-insured arena.

(4). The fourth type of coverage is a variation of number 3. It is variously called Multiple Employer Trusts (METs) (which should not be confused with the union-management Multi-employer plans), or Multiple Employer Welfare Arrangements (MEWAs) (which is the official ERISA and Department Of Labor name for them), or Association plans.

These MET/MEWA/Association plans take the best concepts of both the Taft-Hartley and the single-employer self-insured systems. These METs have expanded tremendously in recent years. In the early 1980s when health insurance premiums began to skyrocket beyond what small employers could pay, many small businesses complained to their associations or local chambers of commerce. Since assocaitions are in the business of trying to solve their members' problems, these associations (sometimes on only a local or state-wide basis and other times on a nationwide basis) established health and other employee benefit plans which their members could join in order to provide coverage for the employees of the member firms of the association. Thus, a group of small employers suddenly had the size and risk-sharing security and marketplace clout to provide cost-effective coverage.

Unfortunately, these Asociation/MET/MEWA plans seem to have been thrown deliberate bureaucratic obstacles. For instance, despite their obvious similarity to Taft-Hartley and self-funded plans under ERISA (ERISA plans are exempted from conflicting state laws), The U. S. Department of Labor seemed to go out of its way to exclude and obfuscate the stituation of these multiple employer plans. The law is so misunderstood and undocumented that most MET plans have been breaking the law for years out of pure misunderstanding. Meanwhile, the states are just as confused. Almost half of the states have laws or regulations on the books which require such plans to show their ERISA "license or certificate" (and the National Association of Insurance Commissioners has a mode law which recommends states have such language). Alas...the Department of Labor, which is in charge of this aspect of ERISA, does not now or ever plan to issue any such "license or certificate" to document what is and is not an ERISA plan. I have made this confession and plea to the Department of Labor on many occasion...but to no avail.

The IRS has also arbitrartily discriminated against association-sponsored plans with the admitted intent of discouraging such plans. In 1981, the IRS began to disallow any association-sponsored MET plan if the membership of the association was wider than one "metropolitan area". There was no documented authority or past history for this abrupt and unannounced reversal of position. Also, though the action was being taken on the basis of the IRC 501(c)(9) status of the health plans, IRS was not taking similar action with any other 501(c)(9) health plans which happened to be sponsored by equally diverse groups as unions and corporate conglomerates.

This has been a devastating blow to the growth of assciation-sponsored health plans and to the employees who are today not covered by health insurance because of this seemingly

arbitrary move. After 6 years of almost constant nagging and pleading, we've made some progress, though cases now stalled in court will continue the deadlock a few more years unless Congress first clarifies its desire in this area. I must, however, give IRS credit for being candid. Their reason for throwing this admitted obstacle to the formation and growth of such assocaition MET plans is that they don't think associations should be "in the insurance business". We would certainly urge you to let your views on this matter be known to the IRS Commissioner and Secretary of Treasury. They say that word from Congress would remedy the situation quickly.

Again, I ask you to assume the employer's position. If you were an employer and saw this kind of consistent and flagrant bureaucratic harrassment of MET/MEWA/Association plans, would you seek to join such a plan or would you be tempted to forget about offering benefits because it is too much hassle?

Since I am being totally candid with you about Uncle Sam's flaws, let me be equally blunt in mentioning that MET plans can be abused (mainly because of the regulatory confusion between state and local authorities). Con-men can easily prey on desperate small businesses who want to offer health coverage, but have to watch their pennies. A MET could be set up as a pyramid scheme. The con-men go out and sell small businesses on a health coverage policy from a MET. Usually, the quoted premium is a considerable saving over the previous coverage. The samll business owner pays his money, gets an official-looking peice of paper, and thinks he's done a good job for his employees. The con-man collects these "premiums" from hundreds of such businesses and when the first big claims begin to come in, the con-man and the money disappear. This is rare, but possible. I can tell you that nothing boils the blood of my SPBA members as fast as hearing about one of these con jobs because it gives the whole concept of self-funding and Multiple Employer Trusts a bad reputation. This kind of con could be more strictly controlled and avoided if MET/MEWAS were regualted exactly like their Taft-Hartley twins: treated as ERISA plans and subject to federal law.

DEFRA's DEADLY BLOW

While all kinds of employee benefits and all sizes of employers have suffered from the buffetting of conflicting government actions, DEFRA (Deficit Reduction Act of 1984/Tax Reform Act of 1984) was one of the harshest blows to businesses attempting to establish cost-efficient single-employer self-funded METS plans. It was passed in the days when the Department of Treasury was in a tizzy because they felt employers were keeping too much money in reserves of their VEBA (Voluntary Employees' Beneficiary Associations - also known as 501(c)(9) plans). The reserves were created for catastrophic claims, shifts in the workforce, and new benefits. We now face AIDs, COBRA, non-discrimination rules requiring coverage of part-time workers, and a host of other new mandated benefits which could bankrupt plans lacking adquate reserves. Although we tried to tell Congress, Treasury and IRS all of this in 1983-84, no one wanted to listen. So, DEFRA, with its limits on reserve levels passed into law with very vague documentation requirements. Shortly after DEFRA passed, IRS realized that our concerns were valid and regretted the reserve limits. Nonetheless, IRS started focusing on other issues and this problem has been swept under the rug, with no hope for regulations providing guidance.

The net effect is that since 1984 many funded health benefit plans have purposely tried to use up their reserves, thus jeopardizing the financial stability of these plans. In addition, many small employers are now dissuaded from joining METs by attorneys and CPAs who warn employer's of the dangers that may come from over-reserving. On the other side, the Third Party Administrator for the plan sees the need to prepare for the major risks that may await down the road and warns employers about the dangers of under-reserving. Hence, the bewildered employer confronts the following choice before providing cost-effective health coverage for his employees through a self-funded plan:

> *(A). Take the risk without adequate reserves and live with the fear of bankrupting his firm and /or his family at any moment. (B). Take the safe and expensive route of buyng a policy from an insurance company or Blue Cross/Blue Shield plan. (C). Just not bother with the hassle and expense of having health benefits for employees.*

You be the judge. Which option would you choose under the circumstances? The DEFRA VEBA reserve limits should be removed from law.

Despite all the financial and government obstacles, employers are still striving to provide health benefits for their empoyees. Through innovative programs (such as self-funding and Multiple Employer Trusts), employers have demonstrated their sincere concern for the welfare of employees and their families. However, the increasing burdens on plans arising from layers and layers of conflicting government policies, laws, and regulations have undercut the employer's ability to extend health coverage. The short-sighted congressional response of mandating various benefits to solve the uninsured problem, without allowing any relief from regulatory confusion, frustrates employers and places them at odds with congressional initiatives. I assure you that employers are interested in providing and upgrading health coverage to employees and they seek your assistance in this endeavor.

Mr. Chairman and committee members, we thank you for carefully reading our testimony and contemplating our concerns. We look forward to discussing any technical quesitions you may have and working with you to solve the problem of the uninsured.

92-265 (172)